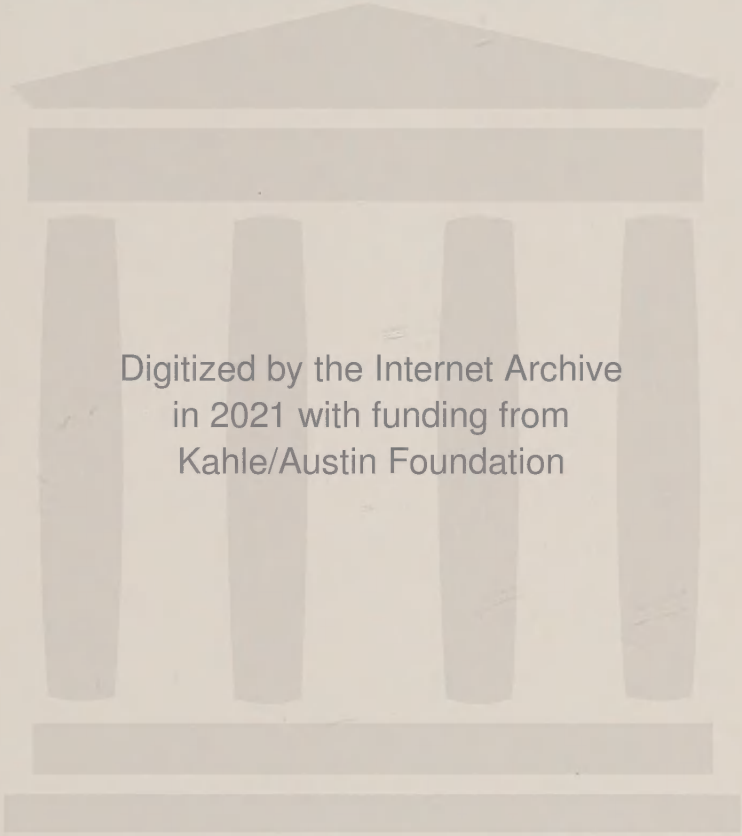

SOCIAL WORK PRACTICE, 1963

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SELECTED PAPERS, 90TH ANNUAL FORUM

NATIONAL CONFERENCE ON SOCIAL WELFARE

CLEVELAND, OHIO, MAY 19–24, 1963

Published 1963 for the

NATIONAL CONFERENCE ON SOCIAL WELFARE *by*

COLUMBIA UNIVERSITY PRESS, *New York and London*

Published by Columbia University Press

Library of Congress Catalog Card Number: 8-35377

MANUFACTURED IN THE UNITED STATES OF AMERICA

Foreword

SOCIAL WORK PRACTICE, *1963* follows the plan inaugurated in 1962 to publish in one volume papers given at the National Conference on Social Welfare which are representative of the social work methods. These practice papers become a companion volume to *The Social Welfare Forum.* In years prior to 1962, papers representing the practice methods of casework, group work, and community organization were issued separately.

Increasingly, however, social work practitioners recognize that the methods of practice are interrelated, and some of the papers in this volume reflect this recognition and explicate the use of more than one method within a given setting or in behalf of a given clientele. At the same time, articles chosen for this volume recognize that whatever other changes in problems and practice may occur, knowledge, skill, and values remain intertwined and indivisible, giving social work those characteristics peculiar to it among the helping professions. Some papers concentrate more on one than on another of these elements of practice, but in those which emphasize new knowledge, it is implicit that such knowledge will enhance skill—and that both knowledge and skill will be used in ways congruent with the values of the profession. And when values are emphasized, the focus is upon values in action.

The profession responds to social needs. Old needs remain, and new needs emerge. New ways of meeting old needs are devised, and that which has proven effective in meeting old needs is used to meet new challenges. There is, however, an increasing insistence within the profession that the choice of one technique or method over another be based on objective evidence of its greater effectiveness. Thus, while the word "research" appears but infrequently in the titles, the findings of research are frequently incorporated in these papers.

The three members of the Editorial Committee who were re-

sponsible for selecting papers for this practice volume aimed to choose those which exemplified new trends in practice or set forth new ideas. However, selection does not necessarily imply the Committee's or the Conference's agreement with the point of view expressed. Furthermore, limitations of space made it necessary for the subcommittee to choose but a small fraction of the many valuable practice papers presented at the 90th Annual Forum.

ELIZABETH G. MEIER, *Chairman of Subcommittee*
CORA KASIUS
FLORENCE RAY

August, 1963

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SOCIAL WORK PRACTICE, 1963

A Project on Family Diagnosis and Treatment

by DOROTHY AIKIN

As EVERYONE KNOWS, there has been for the past few years an increasing, one might say a snowballing, interest in understanding and working with the family as a family. This renewed interest has not been confined to any one setting, though publications have emanated primarily from the family and psychiatric fields of practice. A number of factors have contributed. Suffice it to say that the integration of psychoanalytic theory into social casework theory has left social caseworkers freer to pursue additional sources of knowledge, and the social sciences, having a more dynamic theoretical base than formerly, have been a natural place to turn; there has been concern about "lost cases" or failures; some clients have asked to be seen as a marital pair or as a family, and social caseworkers have heard the request.

The early concern was with family diagnosis and the search for ways of organizing and to some extent simplifying the mass of data that might be gathered about a family. But the question has always been what to do with a family diagnosis if and when one had it.[1] With whom does the caseworker then work?

The project from which I have largely drawn this material developed from a conference on family diagnosis sponsored by the Elizabeth McCormick Memorial Fund in 1959.[2] It was clear to the participants that a sustained experiment by seasoned caseworkers might have considerable merit. Consequently, in the Midwest

[1] No satisfactory classification scheme has as yet been developed, so that diagnostic statements must suffice at present.

[2] See "Proceedings of the Conference on Family Diagnosis," *Social Service Review*, XXXIV (1960), 1–50.

Region of the Family Service Association of America and with the sponsorship of that regional body, fourteen family service agencies agreed to participate in an experiment in practice. Each appointed an experienced caseworker to undertake this assignment. Two of the agencies were merged family and children's service agencies, hence the selection of a child welfare worker was requested, to add another dimension to the experiment. It was deemed important to have workers whose basic skills in practice were established, so that it would be possible to identify difficulties in using a new approach and to avoid confusion of them with the usual learning problems of the beginner. Financing was provided by the McCormick Fund and by the agencies involved. This seminar [3] has met for three days three times a year for three years, fortunately with a minimum of change in the membership.

Each caseworker carried two cases of his case load according to a theoretical framework developed by Otto Pollak, leader of the project, and modified by members of the seminar.[4] This framework was meant to be a guide to be used flexibly as the needs of the case warranted. Our stage of knowledge in October, 1960, was not such that we were willing to require that cases should be fitted into a framework. Nevertheless, a commitment to attempt to achieve certain purposes and to use certain methods was implicit in undertaking the experiment.

The client was considered to be the family rather than an individual in the family, and the purpose of the diagnostic and therapeutic endeavors of the worker was to enhance the family's current social functioning. Naturally, then, it was necessary to find a means of understanding the family's functioning, both in its adaptive and maladaptive expressions, but with some focus. It was

[3] The writer is particularly indebted to the social caseworkers in the Midwest Seminar on Family Diagnosis and Treatment for the opportunity to share in the analysis of their experimental practice.

[4] This framework is contained in Otto Pollak and Donald Brieland, "The Midwest Seminar on Family Diagnosis and Treatment," *Social Casework,* XLII (1961), 319–24. Other articles by members of the seminar are: Emily C. Faucett, "A Re-evaluation of the Home Visit in Casework Practice," *Social Casework,* XLII (1961), 439–45; and "Multiple-Client Interviewing: a Means of Assessing Family Processes," *Social Casework,* XLIII (1962), 114–20; Dwaine R. Lindberg and Anne W. Wosmek, "The Use of Family Sessions in Foster Home Care," *Social Casework,* XLIV (1963), 137–41.

agreed that more than the member(s) of the family who made application to the agency needed to be seen by the caseworker and that the family members should become known, not just in the agency office, but also in the setting that they had created, their home. Here the worker could more readily discern the available or potential strengths of the family; could see, even though a visitor, the habitual ways in which family members reacted to one another, the good functioning and the dysfunctioning; could pick up clues for later treatment; could begin to demonstrate that he was a resource to all members of the family, whether or not all were subsequently included in further interviews. All members of the family knew the worker and his function. He was there, not as a personal friend of the parents, but as a professional person who was going to help the family find some ways of living together with less discomfort and unhappiness. All members could engage in clarifying what it was that the family wanted to be different. The importance of hope that something can be or is being done about a situation is well-known to social caseworkers, both in its power to help persons bear the present because it is temporary and to mobilize motivation to be active for change. So the first home visit contributed to the creation in the family of a therapeutic work group for the purpose of solving a problem—one of the goals of this approach.

The members of the seminar had begun with the assumption that a problem could be identified that troubled most members of the family, directly or indirectly. Hence, the term "most burdensome problem" was used. This might or might not be the problem presented at the time of application or referral. The intent was to define it concretely to the degree that the family members and the worker could together arrive at an agreement about that area of the family life concerning which the family wanted some modification or change, where the motivation to work was likely to be greatest. Such a definition did not rule out the worker's deeper understanding of the genetic or etiological factors contributing to the "most burdensome problem," nor identification of the "core problem," if he had the necessary information to establish it, but he did not set out to get such information. Rather he worked

actively with the family members from the beginning on helping them to understand and clarify what they wanted. The original definition of the problem was somewhat modified. A concept may seem clear and logical initially, but how it works in application is what counts. This concept, "most burdensome problem," underwent a process of testing, much discussion and revision, and came to mean the focus of cooperative effort, that which is mobilizing the family at this time in the here and now, and from which they are seeking relief or change. This problem is a manifest one, out in the open. It can be worked on, and to that purpose there is motivation, and commitment of the family members. By the time this clarity about the problem is achieved, the treatment is well under way, even near completion.

To enhance diagnostic understanding, workers have looked at interaction between family members in the three subsystems of the family: spouse; parent-child; and sibling. Additionally, they have attempted to look at the family as a unit. What does it mean to belong to the Jones family? Does it mean the same thing to each member of the family? Does the family have a goal for itself as a family? If so, what is this goal? Increasingly, workers asked themselves these questions:

What do family members want from one another?

What do family members do for one another in terms of need satisfaction?

What do they do to one another in a damaging way?

What do they withhold from one another?

How does each member perceive himself and the other members as persons and as role performers?

What are the patterns for coping with stress and how did they come about?

In order to change, what would the family members have to give up? What would they have to acquire?

By what methods can this change be effected—through interaction in joint or multiple interviews, in the agency office or at home, through individual interviews with the caseworker, or in what combination?

Social interaction is a basic element in family diagnosis and

treatment, and unfamiliarity with its ramifications troubles many caseworkers who are willing to attempt to treat several family members together. There is some relevant material in small group theory, for example, but adaptation to practice has to be made. Having a theory is not enough, as any social caseworker knows. The nuances are learned in the doing, and a conviction about an approach can come only from experience. Further, the family is a particular type of "small group." It has a permanence and a designated function in our society that differentiate it from small groups formed for specific, temporary purposes. Thus, some of the theory is not relevant. The distillation of that which is meaningful has only begun to be apparent in social work literature.[5]

Social interaction as a concept has a back-and-forth connotation that does not satisfactorily define the process of family treatment, but the seminar members decided to use it as the closest approximation available at the time. With a sociologist, a psychologist, and a social worker experienced in social group work in the seminar, caseworkers had resources for elucidating theoretical applications. Yet on reviewing three years of the project, it is apparent that, although the theoretical framework provided the "push" and encouragement to undertake family treatment, theoretical formulations became meaningful only after experience with the method. One cannot learn to swim sitting on the side of the pool, no matter how clearly the instructor explains the technique. And so it is with family treatment. Some conviction about the desirability of mastery must precede the attempt, but social caseworkers should not wait for precise formulations about methodology before getting into the water. Some guidelines naturally help, but one learns in the doing, analyzing the process, then searching out theory to add depth to the understanding of the experience, even formulating theory from practice.

The process of learning a new approach may be illustrated by

[5] See Grace Longwell Coyle, "Concepts Relevant to Helping the Family as a Group," *Social Casework*, XLIII (1962), 347–54; Mary Louise Somers, "Selected Concepts of Small Group Theory: Their Application to Groups in Rehabilitation Settings and to Community Organization Aspects of Rehabilitation Service," in Mary W. Green, ed., *Proceedings of the Workshop: Practice of Social Work in Rehabilitation* (Chicago: School of Social Service Administration, University of Chicago), pp. 50–67.

examining the application of the concept of social interaction. First, how much can one worker observe of all the interaction taking place between members of the family, verbally and nonverbally, and at the same time participate in the interview? Perception develops as a worker learns what to look for, but some things will be missed. Initially, a worker will grasp only the main trends, perhaps in bits and pieces. Then he wonders when he should intervene in the interaction, when be inactive. How does he promote the interaction of family members with one another, not just with the worker? If he truly believes that members of the family are need satisfiers of one another, then he will feel bound to promote a healthier interaction between members of the family.

As I have observed the experiences and reactions of members of the seminar and of caseworkers in other social agencies, it seems as though there are several stages through which workers go in acquiring skill in an interactional form of treatment. The comfort or discomfort of a worker cannot be the major criterion in the decision about form of treatment; but it is a factor, and some attention needs to be given to it. There is an advantage for workers in a seminar in that there is support for the individual worker through open sharing of experiences and through finding that one's struggles and accomplishments are not unique, that in truth they are part and parcel of the treatment process. These advantages may, of course, be duplicated in agencies or groups of agencies that set out to study intensively a form of treatment. It is difficult for a worker alone to embark on a new approach, even with administrative sanction.

Workers accustomed to interviewing one client at a time typically find the complexity of relationships in a family interview confusing. So much goes on that the worker feels he is subjected to a barrage. In an attempt to avoid being overwhelmed he may become too controlling of the interaction; that is, he may try to direct all communication to himself, even when two members of the family have begun to have a meaningful exchange; conversely, he may retire from it in a state of inactivity, rationalizing that he is observing. While it is true that a worker should not intervene in interaction that he does not understand, he can keep the focus on

the purpose of his presence—the nature of the help the members of the family are seeking and what he and they need to understand in order to do something different, what we have called the "task orientation." Stated another way, the management of the treatment is in the worker's hands, but the management of the family's life is in their hands. The worker is trying to help them manage it better.

Another early tendency is to intervene as soon as the worker understands what he is witnessing, lest he lose an opportunity to help the family perceive what they are communicating. This tendency is like that of the beginner who, on discovering that a child's behavior reflects insufficient mothering, tells the mother to love the child more and the undesired behavior will disappear. Timing is learned gradually. Of solace to beginners in family interviewing is the truism that patterns of interaction will be seen again, even though the content of the expression may differ, that if a form of interaction does not recur the failure to help the family members understand it was not a significant loss. In family treatment, as in any treatment, the discoveries of family members themselves are the most meaningful. The worker is a stimulus to discovery.

Another concern is with the loss the worker feels about having a less intensive relationship with individuals. At first workers may think they should relate to the several individuals as they have learned to do with one. This is patently impossible. The concern is usually expressed in questions about handling the transference, and manifestations of transference and countertransference do interfere in family treatment and must be handled. Because of the involvement of more members of the family, the transference is diluted. No one member of the family has the worker's exclusive attention. Interestingly enough, there has been a minimum of competition for the worker in these cases. Family members seem to grasp that the worker is for the family. For the worker there appears to be a particular gratification in seeing his helping efforts made use of by the family. Transference manifestations are not always expressed in the worker-client relationship but may be seen between members of the family. The transference reactions of the parents have their origin in relationships with persons not usually

present in the interview, but the transference reactions of the children reflect attitudes and feelings about persons who are present, and correction in more direct ways is therefore possible. The incidence of countertransference is tempered to some degree because the worker in focusing on the interaction between individuals is less deeply involved in relationships with individuals. However, workers have been and usually are currently members of a family, have strongly held convictions about the nature of family life, and may find it more difficult to be tolerant and accepting of differences in goals and functioning in family life than they are of differences in individual functioning. It is essential that workers in family treatment be alert to the possible intrusion of their own values.

As self-consciousness lessens and the worker's expectation of himself becomes more realistic, other considerations command attention. In an interactional form of treatment family members perceive more of what another is saying and asking for, and more of what they themselves are saying and doing. In fact, the worker is active to this end. With increase of perception, there is usually improvement in communication between the various individuals and a greater realization of the self-defeating nature of some of the interaction. A change in the interaction may then follow, but not necessarily. If the family members are positively motivated, it may suffice for a child to have the opportunity to express his feelings about the behavior of one or both of his parents toward him, or for one spouse to begin to share with the other the true nature of his reactions to a particular event. In many families, however, unconscious needs are being met through destructive interaction. The caseworker's understanding of the underlying dynamics of the interaction is a necessary forerunner to helping the family members see that, though they have a certain goal, they behave in ways that make achievement of that goal impossible. Something will have to be given up by someone. Confronting members of the family with the contradiction between what they say and what they do will lead to more give-and-take in the family life only if the worker has correctly assessed the readiness of the family members to hear, their capacity to contain some disequilibrium in their relationships, and the reality of their wish to find more construc-

tive ways of having one another's needs met. Caseworkers have said that in family treatment they explain more often what they are doing and why; the family members are taken into the worker's confidence, as it were, about the purpose and direction of the worker's activity, in laying down the "ground rules."

The choice of what thread to pursue lies in another area of skill. Not only the concept of the "most burdensome problem" is helpful, but also that of the indigenous leadership in the family. Who makes the decisions? Who is left out? Does he need the worker's support to find a place to express himself? When the worker demonstrates respect for a depreciated member of the family, it often follows that family members begin to give him a new respect. Can the indigenous leader be helped to act more benignly, for example, in engaging everyone in finding better ways of coping with a conflict or problem? If so, as the family members begin to learn other methods of dealing with stresses in the family, the family will move in the direction of wanting to manage on its own, and the worker's job will be over, at least for the present. The strength of the leadership role that the worker exercises is related to the ability of family members to carry responsibility, as in any treatment.

Intervention in the interaction differs in nature, too. In those instances in which the interaction is actively damaging, the worker's efforts will be in the direction of limitation of the destructiveness. Conversely, when family members are withholding from one another, the intent will be to aid in release of whatever potential there is for giving. Sometimes the worker makes direct suggestions, or demonstrates to the family members a different way of handling a child's behavior, an educative approach, leaving further management to the parents. In essence, the caseworkers in this seminar have demonstrated that a caseworker moves from observation of interaction to identification of the significant patterns, to intervention aimed at modification of self-defeating patterns in the direction of the family's positive wishes, and that a blend of the old and new treatment skills occurs, making it possible to utilize them differentially according to the demands of the case.

A satisfactory definition of family treatment eludes most of us.

Social agency case records bear ample witness to the fact that family life has often been strengthened through the treatment given to one individual who, as a result, began to feel and act differently at home, thus calling forth a more benign response, to which he in turn responded more positively. There are also many instances in which an individual withdrew when he thought he was being asked to carry the total responsibility for all that was going wrong in the family. A seminar to explore family diagnosis and treatment is not a denial of the value of individual treatment. It has an assignment, however, to explore a specific type of treatment, to identify its nature, values, and drawbacks, and to determine some criteria for its use. The seminar has struggled with the question of definition. Is it "family treatment" when the ultimate goal is the strengthening of family life? If so, practically all of casework would be in this category. One could exclude only the treatment of the unattached person. At the other extreme, to state that treatment is family treatment only when all members of the family take part in all interviews places a method above all other considerations. Such inflexibility is unsuited to social casework practice. At this time three components of family treatment have been established:

1. At least two members of the family are being treated by the worker.
2. The family has a goal as a family.
3. The family permits the worker to enter the interaction.

1. It has undoubtedly become apparent that all members of the family are known, for diagnostic purposes, to and by the worker. The locus of the "most burdensome problem" is one determinant; that is, whether the problem is predominantly located in one of the subsystems and the balance of the family is reactive to it, or whether it pervades the total family functioning. Availability of members of the family might seem to be another, but in few instances in cases carried by members of the seminar did persons refuse to be involved. It is probable that these cases are a biased sample of the agency case loads, that workers tended to select cases in which family treatment had a chance to succeed, or at least seemed appropriate at the outset. As family treatment is offered in more agencies and in more cases, the right of an individual to

be included or not will undoubtedly command more direct attention than it has received to date.

Members of the seminar, like many caseworkers who undertake family treatment, began by acceptance of joint or multiple interviews as the method of choice, but with permission to use their judgment as the needs of the case dictated. What gradually emerged was a flexible combination of individual, joint, and multiple interviews, still with the goal of furthering family functioning. Some reasons that workers give for use of individual interviews may be of interest:

a) To teach communication to individuals who do not know how to communicate

The worker sees individuals so that each one may learn first to communicate with him, then better with one another.

b) To permit an individual to rehearse with the worker what he wants to share with a member of the family, which he then does later in a joint or multiple interview

c) To furnish privacy on some matters

It is important to determine who needs the privacy, the client or the worker. While workers may be reluctant to discuss certain subject matter in a group, individuals may well need interviews alone from time to time to replenish a need for privacy.

d) To handle transference manifestations

Workers can develop courage and skill to handle these in joint and multiple interviews, as they appear. Nevertheless, when the interference is sufficiently individual and directed to the worker, individual interviews may be essential to make possible promotion of the family interaction.

e) To help with problems that are essentially individual

There will be facets of the "most burdensome problem" that are individual, subgoals, as it were. Sometimes the worker is helping the individual to get his needs into perspective.

f) To work directly with the individual who is attempting to stir things up or to destroy efforts to improve the interaction

Sometimes he is trying to manipulate the worker to this end, and, of course, such activity cannot be overlooked.

g) To handle the implications of varying rates of growth

The validity of this reason is unresolved. Does a caseworker use individual interviews to let one member of the family catch up, to permit one to go faster than the family group can go, or to help individuals to adjust their expectations of one another to a reasonable level? The differences are already in the family, and the members are living with them. If the family can tolerate them in the family life, it may be possible to tolerate them also in family treatment, depending on the focus of treatment.

h) To break into a defensive interaction that precludes any therapeutic interaction

When family members support one another's pathology and/or defenses, it may be necessary to work first with the individuals, later with them together. Yet the situation has moved in the other direction, too—multiple interviews have been a preparation for individual treatment.

i) To preserve for the child who is placed a relationship to the worker as the agency representative and the bridge to his former life, and perhaps the means back to his family

Thus, in a number of cases individual interviews have supplemented interviews with husband and wife and with parents and children.

The inclusion of children in treatment is a new element for some caseworkers and therefore a matter of concern. Children may be included for observation, for family treatment, or for individual treatment. It is a curious anomaly that social workers tend to identify with children, to want to protect them from damage by their parents, and yet at the same time they feel insufficiently knowledgeable about children to treat them. We have come to believe that the knowledge essential for diagnostic observation of the parent-child and sibling subsystems is, or should be, a part of any social caseworker's equipment and that opportunity for its acquisition is available. Examination of the cases in which all members of the family have been included in treatment leads to the conclusion that the necessary understanding of children for family treatment should be within the competence of any caseworker who sees the children as part of the family system, acting and being acted upon. (Individual treatment of a child, however, calls for special skills.)

A point at issue is whether or not help to the parents in management of the children in the children's presence undermines the authority of the parents. Seminar members think it does not, if the worker is actively supporting the parents to carry their role as parents. The efforts of the parents to perceive what they do and to modify their behavior is caught by the children, and the children are hardly unaware of problems in their family. They may feel considerable relief that some action is being taken. The form which the worker's support takes will vary with the age of the child or children. When a young child is concerned the worker may call his parents' attention to certain behavior and leave them to handle it, or he may demonstrate how to deal with attention-getting behavior or how to set limits. He may, with children old enough to take part in discussion, give support to them to express ideas and feelings about parental handling, involving everyone in consideration of one another's attitudes and in the search for a better solution, on such matters as bedtime, homework, allowances. With adolescents he may aid each person to hear the other in order to make room for the adolescent to grow up in the context of recognition of the impact of aging on the parents. Workers certainly vary in their degree of comfort with children, and in this area, as in others, each one develops a particular style in encompassing the family—and this is the art of social casework.

I do not want to give the impression that treatment of the total family is a simple matter, easily undertaken. Such has not been our experience. Nor do children need to be included all the time. The "most burdensome problem" may exclude them. However, when the problem is viewed in concrete terms, there will sometimes be a shift in the problem being treated, then the decision about who is seen is remade.

2. The family has a goal as a family.

At first glance this might appear to be a meaningless statement. Two individuals must have had some purpose in establishing a family, and yet it has been extraordinarily difficult to discern the purpose in some instances. A family is comprised, of course, of individuals, each of whom has a separate existence, but they are also connected. The concept of family goal is related to the connection. Is the family unclear about its goals or are caseworkers unused to

discerning these goals? Workers have to listen consciously for them and elicit what the family wants as a family, both realistically and in fantasy. Individuals usually seek to have certain of their needs met through the family. As these expectations are stated in one another's presence, certain congruent expectations may emerge, and thus a common goal is seen. If there is no congruence, and the family is thus a collection of individuals, the family may well be on the way to dissolution and family treatment may be inappropriate. If, however, family goals do emerge, the worker and family can work toward agreement about, and achievement of, goals and aims, clarifying that part of the family goal on which the worker and the family will be active. Both strengths and pathology must be taken into account, so that treatment goals will be realistic. Limited treatment goals that enable a family to experience some success are, of course, desirable. Further, they permit earlier termination of the casework, often for consolidation of gains. The family is free to return to the agency when a new stress interferes with their management.

3. The family permits the worker to enter the interaction.

Some opening of the ranks to include the worker is essential, as was implied earlier. The worker cannot foster the family's striving toward its own goals unless he is freely accepted as a resource. In most cases he is able, not only to enter the interaction but also to intervene with the family members toward healthier interaction. In a number of cases, however, family members expressed concern about a problem but would not go beyond the initial complaint. An interview or two in a crisis was all they were prepared to use. Refusal of some family members to be treated would rule out family treatment, also, although in the seminar such refusal was rarely encountered.

Precision and clarity about criteria for choice of treatment have not yet been achieved, though efforts in this direction have certainly been made. Social caseworkers would like to be able to state that in certain types of cases family treatment is most appropriate; in others, optional; and in still others, contraindicated. The seminar results have little to offer in the optional category, since the stated purpose was to experiment with family treatment. The

tendency has been, given a family constellation, to assume that family treatment was suitable, unless evidence clearly indicated otherwise.

Three examples in which approach was deemed appropriate may be cited: families in which one member either cannot or is unwilling to carry the responsibility of the problem and of the treatment; families in which a period of family treatment is essential as a preparation for treatment of an individual member; and families in which a scapegoat is the symptom carrier, and his treatment or removal will leave the family with its problem little touched. Several contraindications have emerged: families in which the needs or goals of an individual predominate; families in which dissolution is the goal; families in which the members use one another as targets for hostility to the degree that the worker cannot modify the interaction; families in which the members are too narcissistic or infantile to work toward a family goal, and a nurturing job of the individuals may first need to be undertaken. Many social caseworkers will have to share experiences before it will be possible to state criteria more explicitly. The volume of such experience is growing rapidly, and before long it should be possible to analyze and systematize this form of practice.

Implicit in success in family treatment is a strong belief in the family, a belief that sends a worker searching for strengths and leads to willingness to attempt family treatment. There apparently is a particular value for the family in being recognized as a family: an increase in the feeling of family identity. Workers have voiced the possibility that family treatment may well be a more effective, even a more economical, method than the traditional approaches. This belief is difficult to substantiate, since a particular case cannot be carried by two different methods, and even control groups have their limitations. Nevertheless, some families have been helped who seemingly could not be engaged in treatment in earlier applications to the agency. It is possible that factors other than a change in the worker's treatment method accounted for the later readiness to involve themselves, but the method should have some weight given to it. It is, of course, true that cases in an experiment receive special attention, and gains may in part reflect this attention. Not-

withstanding, conviction about the value of family treatment is strongly held by those who have developed some skill in it.

Family treatment is not a panacea. Some of the problems encountered in family diagnosis and treatment are encountered in any method in social casework. Uncertainty about the body of theory that is relevant continues, even though strides have been made. Uncertainty about criteria for selection of the appropriate treatment method prevails. Additional obstacles to wide use of family treatment must be noted. Earlier reference was made to the discomfort of the social caseworker while he adds to his body of knowledge and skill. Interviewing space in social agencies has seldom been planned for multiple interviews. As one worker remarked, "My office could not contain the amount of hostility and anger in that family."

Multiple interviews have been found to require more time per interview—commonly an hour and a half—plus travel time to and from the home, if the interviews are held there. Family interviews require at times that the caseworker interview outside his traditional working hours. The one-night-a-week agency office schedule does not suffice. How many evenings, Saturdays, or Sundays can a worker be expected to devote to his practice? Employed members of a family can often be available during the day for a single, diagnostic interview, but seldom for a series, and if the interview is to include children it must be conducted after school hours. These and other administrative questions need further study.

In summary, the essence of family diagnosis and treatment may best be conveyed by quoting from the analysis which one member of the seminar made of a case carried by another:

> I am struck with the validity of this approach with a family which sees itself as a family. If the worker's deep conviction of "family" as a growth-producing milieu and therapeutic agent had been faltering there might have been only partial resolution of and splintering of relationships. On the other hand, it is quite possible the conceptual structure provided a means for growth and fulfillment of worker's satisfactions also as a *family* caseworker.

Research on Alcoholism and Marriage

by MARGARET B. BAILEY

THE SPOUSES OF ALCOHOLICS have long stimulated the interest and concern of social workers, because these marital partners, usually wives of alcoholic men, have appeared in considerable numbers in the case loads of agencies and clinics and have typically presented a challenge to the professional skills of those whose purpose was to help them. The traditional question has been concerned with the relationship between the personality structure and characteristics of wives of alcoholics and the onset, continuance, and resolution of their husbands' drinking problems.

Two recent reviews of the literature, by Jackson [1] and by Bailey,[2] summarize and discuss the state of knowledge in this area three or four years ago. Most of the published literature at that time consisted of clinical papers and case reports, which offered little in the way of encouragement to the social work practitioner. Currently, several organizations are conducting major research programs on alcoholism and marriage, but many of the findings are as yet unpublished. To the extent that this research has been partially reported, it appears to shed new light on the alcoholic marriage and to suggest a reorientation of professional thinking and practice.

Psychiatrists and social caseworkers, who first gave serious professional attention to the alcoholic marriage, formulated a clinical description of the personality of the wife of the alcoholic, which

[1] Joan K. Jackson, "Alcoholism and the Family," in David J. Pittman and Charles R. Snyder, eds., *Society, Culture, and Drinking Patterns* (New York: John Wiley and Sons, Inc., 1962), pp. 472–92.

[2] Margaret B. Bailey, "Alcoholism and Marriage: a Review of Research and Professional Literature," *Quarterly Journal of Studies on Alcohol,* XXII (1961), 81–97.

until recently was accepted as a guide to practice. The wife was almost universally regarded as a disturbed, poorly integrated woman who married an alcoholic, or potential alcoholic, in order to satisfy her unconscious need for a weak and dependent husband. Some authors stressed the wife's need to feel strong in relation to her ego ideal of a woman, as represented by her own dominant mother.[3] Others emphasized her sexual anxiety as playing a major role in her attraction to an alcoholic mate presumed to be sexually inadequate.[4] In spite of some differences in their analyses of the underlying causes of the wife's personality disturbance, these clinical and case reports were generally consistent in their belief that the wife of the alcoholic was able to maintain a semblance of adequacy only at her husband's expense, that she had a vested interest in maintaining his active drinking, and that she was likely to decompensate emotionally if her husband should begin to recover from his illness.[5] Thus the alcoholic marriage was conceptualized as an expression of the preexisting psychopathology of both marital partners.

A contrasting theoretical orientation was first introduced in 1954 by Jackson, a sociologist who engaged for several years in participant observation of an Al-Anon Family Group, a fellowship for relatives of alcoholics associated with Alcoholics Anonymous. In a now classic paper, Jackson suggests that the alcoholic marriage might be regarded as a particular form of response to stress. She hypothesizes that the behavior of the wife and the neurotic traits inferred from this behavior are reactions to a cumulative crisis. Thus similar observations about the disturbance of wives of alcoholics might primarily reflect the similar stresses which they are undergoing in the role adjustments necessitated by their husbands' progressing alcoholism. Jackson goes on to describe a series of seven typical stages in family adjustment to this illness: attempts

[3] Samuel Futterman, M.D., "Personality Trends in Wives of Alcoholics," *Journal of Psychiatric Social Work*, XXIII (1953), 37–41.

[4] Margaret L. Lewis, "The Initial Contact with Wives of Alcoholics," *Social Casework*, XXXV (1954), 8–14.

[5] Donald E. Macdonald, "Mental Disorders in Wives of Alcoholics," *Quarterly Journal of Studies on Alcohol*, XVII (1956), 282–87.

to deny the problem; attempts to conceal it; family disorganization; attempts at reorganization of family roles; efforts to escape the problem by separation; reorganization of the remaining part of the family; and, finally, recovery of the husband and reorganization of the family as a whole.[6]

Lemert, in 1960, attempted to test Jackson's hypothesis about the stages of family adjustment to alcoholism. He proved unable to demonstrate seven discrete stages, since in his series of cases events sometimes occurred out of order or were found to cluster. In some families there appeared to be no denial phase, and others seemed to move almost directly from recognition to reorganization without going through a stage of prolonged disorganization. Lemert concludes, however, that his data supports Jackson's major conclusion that the behavior of wives of alcoholics reflects in large measure the changing interaction patterns in the family and cannot be regarded merely as an expression of preexisting psychopathology.[7]

In the past few years, various investigators have begun to test hypotheses about the personality of the wife of the alcoholic. Findings have differed considerably on the question of whether these women marry men who are already alcoholics. In her study of Al-Anon members, Jackson reports that at the time of marriage, most of the husbands were drinking within socially acceptable limits. A few, who were already alcoholic, managed to conceal the extent of their drinking, and the small number of women who were told about the alcoholism had no concept of what it meant.[8] Clifford, on the other hand, studied the wives of fifty alcoholic clinic patients and suggests that all of these women had been aware of their husbands' alcoholism before marriage.[9] Unfortunately, he does not specify the evidence on which he bases his judgments.

[6] Joan K. Jackson, "The Adjustment of the Family to the Crisis of Alcoholism," *Quarterly Journal of Studies on Alcohol,* XV (1954), 562–86.

[7] Edwin M. Lemert, "The Occurrence and Sequence of Events in the Adjustment of Families to Alcoholism," *Quarterly Journal of Studies on Alcohol,* XXI (1960), 679–97.

[8] Jackson, "The Adjustment of the Family. . . ."

[9] Bernard J. Clifford, "A Study of the Wives of Rehabilitated and Unrehabilitated Alcoholics," *Social Casework,* XLI (1960), 457–60.

Lemert concludes from his 112 cases, drawn from 5 different sources, that 52 percent of the women had married men who were already alcoholics.[10]

The National Council on Alcoholism, in its current study of 262 wives of alcoholics,[11] drawn also from a variety of agency sources, has obtained fairly extensive data concerning the premarital drinking of alcoholic husbands. The wives in this study were questioned about their own observations of their fiancés' drinking patterns and behavior, and also about statements and warnings they had received from others. After analyzing these data, the researchers conclude that 34 percent of these women had been presented before marriage with some evidence that their fiancés had a drinking problem. On the other hand, the husbands of 29 percent of the women had shown evidence that they did not drink excessively before marriage. In the remaining 37 percent of the cases, the researchers were unable to make a judgment, since the husbands' premarital drinking patterns, as observed by their wives, were not sufficiently clear-cut. It is noteworthy that though 34 percent were presented with evidence of abnormal drinking during courtship, only 13 percent said that they actually recognized this as a problem prior to marriage. Even in retrospect, more than one third of the women were of the opinion that their husbands developed alcoholism after the marriage.

These findings suggest that wives of alcoholics marry men who exhibit a wide range of drinking behavior, from normal to pathological, during the courtship period. The fact that alcoholism may not develop until some years after marriage does not, however, rule out hypotheses about neurotic complementarity in mate selection. The evidence on this point is much harder to obtain, since, of course, these couples have not usually been psychiatrically evaluated before marriage. Hence data have to be obtained and analyzed *ex post facto*. Lemert, in his study of 112 wives of alcoholics, became interested in questions concerning the wife's dominance and the husband's dependency. He found that men who

[10] Lemert, *op. cit.*

[11] This project is supported by Mental Health Project Grant OM-261, U.S. Public Health Service.

were already alcoholic at the time of marriage were more likely to be dominated by their wives, were more often irresponsible, and were more dependent, both financially and emotionally, on their wives or parents or both.[12]

Kogan, Fordyce, and Jackson have recently studied the current personality disturbance of fifty wives of actively drinking alcoholics, as compared with that of fifty wives of nonalcoholics of similar age and socioeconomic status. These investigators administered the Minnesota Multiphasic Personality Inventory (MMPI) to their 100 subjects and report that the wives of alcoholics did exhibit more generalized personality distress than the control group. Less than half of the wives of alcoholics, however, fell in the impaired category, and no specific pattern of personality dysfunction could be identified as characteristic of these women.[13]

In similar vein, the National Council on Alcoholism used an Index of Psychophysiological Disturbance, which had been developed and employed in a community mental health survey. Wives of alcoholics had a higher proportion of elevated scores than wives in the general population, but the differences were relatively small except for those women who were living with actively drinking husbands. Wives whose husbands were recovering from alcoholism and those who had terminated their marriages had scores which were only slightly higher than the scores of women of comparable marital status in the representative community sample.[14]

Several investigators have become interested in the outcomes of alcoholic marriages, particularly as related to the characteristics of the wife. For example, how do alcoholic marriages which terminate differ from those which continue? If the marriage remains intact, what characteristics of the wife are associated with the husband's recovery, as compared with the characteristics of women whose alcoholic husbands continue to drink?

[12] Edwin M. Lemert, "Dependency in Married Alcoholics," *Quarterly Journal of Studies on Alcohol,* XXIII (1962), 590–609.

[13] Kate L. Kogan, Wilbert E. Fordyce, and Joan K. Jackson, "Personality Disturbance in Wives of Alcoholics," *Quarterly Journal of Studies on Alcohol,* XXIV (1963), 227–38.

[14] Margaret B. Bailey, Paul Haberman, and Harold Alksne, "Outcomes of Alcoholic Marriages: Endurance, Termination or Recovery," *Quarterly Journal of Studies on Alcohol,* XXIII (1962), 610–23.

In comparing marriages with different outcomes, the National Council on Alcoholism found that wives who terminated their marriages to alcoholics had been subjected to more economic stress and more patholological behavior on the part of their husbands than had the women who remained married. In the broken families, the men had relatively low occupational status, small earnings, and more loss of employment, so that their wives were more likely to be regular members of the labor force. These women with terminated marriages also reported more physical abuse from their husbands, more contact with the police, and more infidelity.[15] These findings are corroborated by Jackson and Kogan, who report that the divorcing wives in their series of cases had experienced greater hardship in terms of the husbands' job loss, physical abuse, and police contacts than the women who maintained their marriages. The divorcing wives in this study exhibited relatively low anxiety levels and high ego strength on the MMPI.[16]

It has proved more difficult to pinpoint differences between women whose husbands recover from alcoholism and those whose husbands continue to drink. Clifford reports that wives whose husbands had achieved sobriety showed genuine concern about social and psychological damage to their children, accepted some measure of responsibility for their husbands' drinking, felt indispensable to their husbands, and were more conscious of social ostracism and embarrassment.[17] Data from the National Council on Alcoholism's study contain a suggestion that alcoholic families in which the husband recovers tend to be ambitious and upwardly mobile, with the wife noticeably concerned about economic security, social ostracism, and growing isolation from friends.[18]

On the other hand, Kogan and Jackson administered the LaForge and Suczek Interpersonal Checklists to twenty wives of alcoholics whose husbands had been sober at least twelve months and twenty women whose husbands were still drinking. These investigators found no differences between these two groups in regard to

[15] *Ibid.*

[16] Joan K. Jackson and Kate L. Kogan, "The Search for Solutions: Help-seeking Patterns of Families of Active and Inactive Alcoholics," *Quarterly Journal of Studies on Alcohol* (in press).

[17] Clifford, *op. cit.*

[18] Bailey, Haberman, and Alksne, *op. cit.*

personality variables. Abandoning the distinction between drinking and sober husbands, Kogan and Jackson were able to divide the forty wives of alcoholics in this series into three meaningful categories: (*a*) those who perceived all husbands, including their own, as essentially hostile, whether drunk or sober; (*b*) those who regarded most men as hostile, but saw their own husbands as likable, though ineffectual, when sober; and (*c*) those who conceived most husbands as likable and their own as equally so when abstaining, but as different personalities when drinking.[19] This report thus adds another piece of evidence to the previous findings of these same investigators that wives of alcoholics are not a unitary group from the point of view of personality.

The hypothesis that wives of alcoholics have a vested interest in maintaining their husbands' active drinking and tend to decompensate emotionally when the latter begin to recover has not received support from the research reported here. On the contrary, Jackson has commented that during her eight years of participant observation of an Al-Anon group in Seattle, she has observed only one wife of an alcoholic who showed an increase in emotional disturbance of more than a temporary nature when her husband achieved lasting sobriety.[20] Transient disturbance, it should be added, is fairly common, since roles must be readjusted to the new state of sobriety, and many wives who have played a major part in maintaining family stability during the drinking years are reluctant to relinquish their dominant roles until they can develop some confidence in their husbands' lasting sobriety.

The evidence available from Jackson's work and from that of the National Council on Alcoholism suggests that following this transient period of role realignment, the wives' adjustment appears to improve in most cases as the duration of the husbands' sobriety increases. The collection of research data on this point is, of course, somewhat difficult, inasmuch as wives must generally be questioned or tested *ex post facto*. Nevertheless, there is some evidence that wives of alcoholics are less disturbed when they are no longer ex-

[19] Kate L. Kogan and Joan K. Jackson, "Some Role Perceptions of Wives of Alcoholics," *Psychological Reports*, IX (1961), 119–24.

[20] Jackson, "Alcoholism. . . ."

posed to their husbands' active drinking. The research staff of the National Council on Alcoholism found that separated wives reported a diminution of psychophysiological symptoms after termination of their marriages, and that wives of recovering alcoholics believed their symptoms had decreased even more since their husbands had stopped drinking.[21] These findings are highly tentative and require replication before they can be fully accepted, but they do nevertheless cast some doubt on the validity of the decompensation hypothesis as applied to the majority of wives of alcoholics.

The failure to discover a unitary personality structure for wives of alcoholics and the current interest in alcoholism as a particular instance of family stress have led logically to study of role perceptions and relationships. Mitchell and Ballard, the first to conduct such research with alcoholics, had as their subjects couples who had sought clinic help for their marital difficulties. Some of these conflicted marriages involved alcoholism and others did not, so that it was possible to obtain a nonalcoholic control group. Administering the MMPI to these couples, Ballard found that the nonalcoholic husbands showed greater social dominance than their wives, in contrast to the alcoholic marriages, where the wives seemed to have assumed more of this characteristic. In the alcoholic marriages, the wives appeared better adjusted than the husbands, whereas in the control group of conflicted, but nonalcoholic, couples, the husbands proved to be somewhat less disturbed.[22] Mitchell, studying the same couples, explored the application of interpersonal perception theory to the alcoholic marriage. His report discusses the alcoholic husband's sensitivity and tendency to be easily hurt, which the wife failed to appreciate, and his perception of her need to control and dominate, which she minimized in herself.[23]

Kogan and Jackson have also studied the role perceptions of

[21] Bailey, Haberman, and Alksne, *op. cit.*

[22] Robert G. Ballard, "The Interaction between Marital Conflict and Alcoholism as Seen through MMPI's of Marriage Partners," *American Journal of Orthopsychiatry,* XXIX (1959), 528–46.

[23] Howard E. Mitchell, "Interpersonal Perception Theory Applied to Conflicted Marriages in Which Alcoholism Is and Is Not a Problem," *American Journal of Orthopsychiatry,* XXIX (1959), 547–59.

forty wives of actively drinking alcoholics and of forty wives of nonalcoholics. Using the LaForge and Suczek Interpersonal Checklists, these investigators report that the wives of alcoholics perceived their husbands, whether drinking or not, as socially undesirable, lacking in emotional warmth, and as gloomy, distrustful, and bitter. These wives of alcoholics described themselves as less dominant and managing than did the control wives. They also more frequently expressed passivity and adherence to stereotyped feminine and wifely roles.[24] These findings seem somewhat surprising in view of the presumed dominance of wives of alcoholics, but in the Mitchell study just cited, the wives did not perceive in themselves the dominance attributed to them by their husbands. In the Kogan and Jackson study, the husbands were not included, so that their responses could not be compared with those of their wives.

The National Council on Alcoholism has just begun a study of husbands and wives in alcoholic and nonalcoholic marriages, in an effort to explore distinctive characteristics in the family interaction of alcoholics.[25] Respondents will be drawn from a representative community sample, rather than from a clinic or agency population.

Research on marital interaction, as applied to alcoholism, is still very new but would seem to provide a more fruitful approach than continuing study of the personality of one spouse. Up to this time, findings about role perceptions have generally been based on group averages rather than on study of the relationship between a particular husband and wife. The application of role theory to the marital interaction of specific couples might well provide practitioners with an opportunity to contribute to the growing body of knowledge about the alcoholic marriage.

With the alcoholic marriage, as with any other problem category, the social worker's practice will inevitably be guided by his conceptualization of the nature of the disturbance. It is generally accepted that the man or woman married to an alcoholic has serious difficulties, but until very recently the social worker has been con-

[24] Kate L. Kogan and Joan K. Jackson, "A Comparison of the Role Perceptions of Wives of Alcoholics and Non-Alcoholics," *Quarterly Journal of Studies on Alcohol* (in press).

[25] This project is supported by Grant U-1254 of the Health Research Council of New York City.

fronted with two contradictory and untested hypotheses as to the nature of the trouble.

In describing the wife of the alcoholic, the clinical literature has generally presented the picture of a woman whose emotional disturbance antedated her marriage and whose personality is expressed in her interaction with her husband, but is not changed by this relationship. Although the search for "the alcoholic personality" has proved fruitless, the search for a type of personality called "the wife of the alcoholic" has persisted.[26] The sociological literature, on the other hand, has regarded similarities in the behavior of wives of alcoholics as resulting from similar stresses and role adaptations to which these women are subjected by the nature of their husbands' illness. The two approaches have proceeded with insufficient cross fertilization, with the clinicians largely ignoring necessary social role adjustments and the sociologists failing to take individual personality into account. The alcoholic marriage has long needed an integrated psychosocial approach, a way of thinking and acting in which social workers have traditionally shown special competence.

The research which I have summarized has only begun to answer some of the relevant questions which may be raised. Most important, perhaps, is the discovery that the personality of the alcoholic's wife must be regarded as a variable in marital interaction rather than as a constant. Though wives of alcoholics are more disturbed than groups of "normal" women with whom they have been compared, no single type of disturbance has been identified, and, in addition, many wives of alcoholics, according to test results, do not appear to be seriously impaired.

One clue, which may be important for the practitioner's differential diagnosis, concerns the extent of the husband's premarital drinking and whether the alcoholism preceded marriage or developed later. The discovery of an association between premarital alcoholism and postmarital dependency of the husband opens up a possibly important avenue for exploration. There may be great differences between women who marry men whose drinking is already out of control and women whose husbands become alco-

[26] Jackson, "Alcoholism. . . ."

holic after a period of marriage. Careful history-taking by the practitioner may clarify this point of differential diagnosis.

Several outcomes for the alcoholic marriage are possible, though most of the clinical literature has described only those couples where the wife continued to live with an actively drinking husband. On the other hand, it is known that a disproportionately large number of alcoholic marriages terminate in divorce or separation. These cases may not be readily visible to social workers in family agencies and clinics, though they are well known to the courts. Women who terminate their marriages to alcoholics have been reported as suffering more economic hardship and more abusive behavior than wives who continue such marriages. The masochism of these divorced and separated wives of alcoholics does not appear to have been unlimited.

In considering alcoholic marriages which are maintained, it appears to be more difficult to differentiate between the wives whose husbands recover and those whose husbands continue to drink. If it should be confirmed that the families which recover are more ambitious, more upwardly mobile, and more concerned about social relationships, this may simply reflect a greater stake in recovery. It may be, of course, that the wife's personality characteristics are not necessarily decisive for the husband's recovery or continued drinking. This question needs much further investigation and is, in fact, a somewhat revolutionary hypothesis, for as Jackson has pointed out, the trend toward considering the wife as a complicating factor in her husband's illness has almost "advanced to the point where the alcoholic has emerged as the innocent victim of his wife." [27] Yet the Al-Anon Family Groups, which appear to have been more successful than the professionals, have long taught their members that the wife of an alcoholic is "powerless" to stop her husband's drinking and that the decision and the commitment to recovery must be his. The extent to which the wife can facilitate or impede this process is still unknown.

There are undoubtedly some women who fit the classic clinical description of the wife whose semblance of adequacy requires the continued drinking of her husband. Evidence from current re-

[27] *Ibid.*

search suggests, however, that this generalization does not universally apply and that the majority of wives of alcoholics have the potentiality for recovering along with their husbands.

Though many questions are still unanswered, it is reasonable to anticipate that the various ongoing studies will continue to produce material which will contribute to the practitioner's understanding. In the meantime, current findings suggest the abandonment of easy generalizations about *the* wife of *the* alcoholic and the need to take a fresh look at the interaction between particular husbands and wives. Each spouse brings his or her basic personality to the marriage, it is true, but the expressions of this personality are not constant and are affected by the progression of the alcoholism, which by its very nature imposes role readjustments on the family. The alcoholic's wife is neither innocent victim nor villain, but a participant in interaction which becomes more mutually destructive as the alcoholism progresses. When one of the marital partners seeks help, the professional person has an opportunity to break through this destructive interaction and to contribute to the recovery of the marriage, or at the very least to help the disturbed spouse adapt with less anxiety and resentment to the husband's illness.

Values and Aspirations as a Focus for Treatment

by ARTHUR BLUM

SOCIAL WORK AS A PROFESSION, and especially social group work, has from its inception been dedicated to examining, and attempting to do something about, its own value orientation and the value orientations of the groups which constitute our society. Tremendous amounts of time and energy have been devoted to discussions of values. One entire volume of the social work curriculum study deals with values and ethics in social work education.[1] Cohen views social work as "humanitarianism in search of a method" and utilizes his entire first chapter to discuss values in relation to social work goals.[2] Lindeman refers to the value system as rules of conduct which constitute the democratic disciplines and act as "directional finders." [3] In group work we talk about helping people in their attempts to "achieve socially desirable goals," [4] to develop "a sense of responsibility for active citizenship," [5] and to learn "the democratic way of life." Even this exceedingly small sampling of social work writings on values indicates our concern for our own values as professionals, the values of our individual

[1] Muriel W. Pumphrey, *The Teaching of Values and Ethics in Social Work Education,* The Comprehensive Report of the Curriculum Study, Vol. XIII (New York: Council on Social Work Education, 1959).

[2] Nathan E. Cohen, *Social Work in the American Tradition* (New York: Dryden Press, 1958).

[3] Eduard C. Lindeman, "Functional Democracy in Human Relations," in Lloyd Allen Cook, ed., *Toward Better Human Relations* (Detroit: Wayne University Press, 1952), pp. 21–34.

[4] Statement adopted by the Executive Board of the American Association of Group Workers, 1949.

[5] Statement developed for the Committee on Practice of the Group Work Section of the National Association of Social Workers, 1961.

clients, and the values of society. It has been said that it is this concern with values that makes social work "social."

It is, therefore, surprising or, to put it more dramatically, shocking that with all our concern about values so little of the social work literature deals with this area in a systematic way as a focal point for treatment. We are heavy on words but light on theory. In social work education we have given more time and effort to designing ways to affect students' values than we have to systematically affecting the values of clients and social institutions.

As we have utilized personality theory, there has been considerable effort given to the development of typologies, that is, neuroses, character disorders, and so forth, and, deriving from the dynamics associated with the typologies, diagnostic prognoses and treatment interventions have been formulated. Right or wrong, completely useful or partially useful, clear or ambiguous, these efforts have at least provided for the social worker a more systematic way of assessing the individual and planning treatment. More important, perhaps, these formulations can provide a foundation for discussion, criticism, and controversy which help identify the issues and establish a base from which one can deviate as the theory proves inadequate. They focus concern and force those who disagree to support their position and to create new systems for analysis. The danger of rigid adherence to outmoded ideas is ever present, but even this negative aspect of theorizing stimulates others to question and challenge.

In relation to values, however, typologies have been avoided, definitions have been vague, diagnostic statements with associated dynamics lacking, and interventions have been global with little theoretical basis but much conviction. Thus, it becomes difficult to evaluate situations in which the workers are sincerely in favor of good and against evil. But are there levels of "goodness"? Are some values more important than others? Are there different treatment approaches which should be related to different deviations which are the result of value distortions? The questions could go on and on, but the point has been made and the critical question becomes: What are we going to do about it?

It would be rewarding to be able to say that what follows is the

answer to this question. This is not the case; rather, it is a beginning formulation which will need considerable development in the future. My purpose in presenting it is to stimulate thought and bring some of the issues into focus.

All of us have been exposed to the growing body of literature which vividly points out the deterioration in the value orientations of segments of our society. We have been described by various authors as a lonely crowd [6] growing up absurd [7] in an insane society [8] composed of status seekers,[9] exurbanites,[10] organizational men,[11] and the invisible poor.[12] These writings and titles describe symptoms of extensive distortion in our goals and aspirations. Further testimony to the extent and varieties of social pathology are our monumental rates of psychosis, neurosis, alcoholism, crime, delinquency, poverty, divorce, and suicide, as well as our inability to deal effectively with an even wider range of social welfare problems. We are faced today with a "value depression" which, in the long run, may be more devastating than an economic depression.

The problem thus becomes one of understanding the elements of this "value depression" or, put another way, of diagnosing it in a way which will enable us to derive treatment strategies and interventions. What we do must be related to the problem, but in order to accomplish our ends we must be aware of what the problem is and the relationships among the factors which combine to create it. The material which follows draws heavily upon the work of Merton [13] and Durkheim [14] and attempts to build upon the formulations of Cloward and Ohlin [15] and Sarnoff,[16] with the hope of

[6] David Riesman, *The Lonely Crowd* (New Haven: Yale University Press, 1950).

[7] Paul Goodman, *Growing Up Absurd* (New York: Random House, 1960).

[8] Erich Fromm, *The Sane Society* (New York: Rinehart, 1955).

[9] Vance Packard, *The Status Seekers* (New York: D. McKay Co., 1959).

[10] A. C. Spectorsky, *The Exurbanites* (Philadelphia: Lippincott, 1955).

[11] William H. Whyte, Jr., *The Organization Man* (New York: Simon and Schuster, 1956).

[12] Michael Harrington, *The Other America: Poverty in the United States* (New York: Macmillan, 1962).

[13] Robert K. Merton, *Social Theory and Social Structure* (rev. ed.; Glencoe, Ill.: Free Press, 1957).

[14] Emile Durkheim, *Suicide: a Study in Sociology* (Glencoe, Ill.: Free Press, 1951).

[15] Richard A. Cloward and Lloyd E. Ohlin, *Delinquency and Opportunity* (Glencoe, Ill.: Free Press, 1960).

[16] Irving Sarnoff, "Juvenile Delinquency and the Social Psychology of Limitless

adding further to the understanding of the phenomenon, especially in relation to the development of personality.

Values, as indicated by Merton,[17] can, theoretically at least, be divided into two broad classifications: (1) aspirations, or "things worth striving for"; and (2) instrumentalities, or the means used to satisfy the aspirations. This differentiation of means and ends is of extreme importance. Psychologically, aspirations can be considered as states of tension resulting from unmet needs or motives which are directed toward specific goals. These needs may be, and often are, the products of biological and emotional drives, but they must pass through the cultural "value screen," which shapes them and gives them direction for fulfillment. Drive energy can be displaced in such a way that the aspirations of the individual can become the motivational force that guides his behavior. Thus, cultural values become the intervening variable between the drive and its related tensions and the reduction of the tension.

Aspirations or goals can be further divided into two broad categories: (1) "grasping" aspirations, which necessitate the person's taking or receiving something from others to fulfill his aspirations; and (2) "giving" aspirations, which necessitate the person's giving something of himself to others in order to fulfill his aspirations. Material gain, power, and prestige can be grouped as grasping aspirations. Humanitarianism, creativity, intellectualism, and spirituality can be included in the group of giving aspirations. The individual, for example, who pursues intellect for intellect's sake with the end goal of making a contribution to knowledge and mankind can be referred to as having intellectualism as an aspiration that motivates his behavior. It must be recognized, however, that another individual may use intellect as a means to achieve his aspirations for material gain, power, or prestige. In the latter case, intellect has been corrupted into a means value, or the way of achieving another end, and is no longer the basic aspiration. This difference between aspirations or ends and the means used to achieve them is not always easily distinguishable. However, identi-

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Aspirations" (Cleveland: School of Applied Social Sciences, Western Reserve University, 1961; mimeographed).

[17] Merton, *op. cit.*, pp. 132–33.

fying the basic motivation and differentiating it from the means is crucial if one is to understand the behavior. And it is only as we understand the behavior that the planning of appropriate interventions becomes possible.

In the growth and development of the individual, the formation of grasping aspirations can be related to drives which must be satisfied early in the life of the child. The infant, to survive, must cultivate behaviors which will bring him a response from those who care for him, and his biological needs are satisfied to the extent that he is able to derive sustenance from his environment. He develops a grasping orientation, and his needs are met only to the degree that the environment is able to give to him. Diagnostic categories and psychoanalytic terminology deal extensively with this process—oral aggressiveness, anal aggressiveness, passive aggressiveness, and a similar range of terms referring to the satisfaction of dependent needs. In Freudian terminology, this behavior is grouped together and described by the theoretical construct, of the "pleasure" principle. But as the child grows and develops, he slowly begins to learn to withhold his need for immediate gratifications for the sake of future gains and to become more aware of his environment, especially his relations to other people. He experiences satisfaction from giving to others as well as receiving from them, and he is able to relieve inner tensions through productive efforts of his own and through self-satisfying experiences. This change in orientation has been termed the "reality" principle.

To function on the level of the reality principle, however, the individual must have obtained some minimal satisfaction of his earlier needs. We often refer to people who have not received these basic gratifications as persons who are like a "bottomless pit" or, more accurately, like "quicksand." They grasp and swallow up everything within their reach but are never satisfied, and one cannot even see what has been devoured as they lie in wait for the next feeding of their insatiable appetite. The problem is: How does one assess what is this minimal need for proper development and where does the environment provide opportunities for satisfactions? What opportunities are provided, what behavior is re-

warded, and what aspirational orientation brings approval and satisfaction?

Our society today gives much recognition to those who can successfully pursue a grasping orientation. Material gain, power, and prestige have become primary goals, while those who pursue the goals of humanitarianism, intellectualism, creativity, and spirituality are considered to be "odd" or "suckers." These giving aspirations are no longer goals to be achieved; they have become prostituted and distorted into the means whereby one achieves his grasping ends. Intellect is pursued, not as an end, but as a necessary means of obtaining money, power, and prestige. Some industrial and business concerns assign vice presidents to serve on agency boards and welfare federation committees, not as an expression of their humanitarian commitment, but rather for the sake of good public relations or so that they may guide decision-making.

Yet, as we consider the developmental process, we see that it is the humanitarian, creative, intellectual, and spiritual aspirations which are the socializing mechanisms. They act as social controls which transform us from grasping tyrants into giving human beings. They are, however, aspirations which come to the fore later in life and can flourish only if earlier needs are satisfied and if they are nurtured and supported in the environment. To give to others, one must be given to. And the extent of the ability to give will depend on the individual's perception of how pervasive has been the giving to him. Whether the individual develops a giving orientation to his immediate family, to his cultural group, and to the wider society will depend on whether he has perceived these various social systems as having given to him.

What we have outlined, thus far, is that an individual begins as a grasping infant and develops into a socialized person as he blends his giving and grasping aspirations. Unfortunately, perhaps, it is unlikely that man can have a totally giving orientation and still function adequately in a Western civilization. Our goal must be rather to harmonize the two. One can speak of this as the creation of an internal conflict, but much of man's functioning is directly related to a balance of conflictual dynamics, that is, pleasure-pain,

aggression-love, good-evil, being-becoming, and so forth. In each instance, the goal is balance.[18]

Before attempting to utilize this framework as a means of diagnosing deviant behavior, two additional concepts must be introduced. The first of these is Durkheim's concept of "unlimited aspirations," [19] paraphrased and further developed by Sarnoff as "limitless aspirations." [20] This concept describes the process whereby the individual may experience a reduction of tension when he has achieved his goal; but attainment provides only momentary satisfaction as he tends then to lift the goal to new heights, thus creating new tensions. This is an important observation for those of us who are engaged in the process of value change. It means that if a person has a grasping orientation, and we set out only to satisfy his need for material gain, power, and prestige, we have stepped onto an endless escalator requiring us to meet ever increasing demands with no place for escape. The goal must be one of attempting to insert some dedication to a giving orientation so that the balancing force becomes internalized. As stated earlier, the individual must receive at least some minimal satisfaction of his grasping aspirations before he is even amenable to giving influences. I cannot say what is minimal, but the basic requirements of food, clothing, shelter, a job opportunity, and someone who cares seem crucial. Operating from this base, we must consciously aim also at encouraging the development and growth of giving aspirations if we are to have truly socialized individuals.

The second concept which is essential to the analysis is Merton's differentiation of legitimate and illegitimate means of achieving one's aspirations.[21] Perhaps social workers would prefer to use the continuum socially acceptable to socially unacceptable means of achieving aspirational ends. Regardless of the individual's aspirations, he must choose what means he will use to pursue his ends. He

[18] The blending of "incompatible or potentially incompatible norms into a functionally consistent whole" is discussed in relation to medical education in Robert Merton, George Reader, and Patricia Kendall, eds., *The Student-Physician* (Cambridge, Mass.: Harvard University Press, 1957), pp. 74–76.

[19] Durkheim, *op. cit.*, pp. 246–54. [20] Sarnoff, *op. cit.*, pp. 18–25.

[21] Merton, *op. cit.*, pp. 132–41.

can remain within the bonds of society or he can resort to socially unacceptable modes of behavior in reaching these ends. Cloward and Ohlin vividly point out that if there are barriers to the use of socially acceptable means the individual may develop means which are socially unacceptable in order to reach his ends.[22] Thus, behavior must be diagnosed in relation to the person's aspirations and the means utilized to achieve these ends. Interventions, likewise, must be considered in relation to whether change in aspirations or change in means is the goal, or both. Where is the emphasis being placed? Will the same interventions accomplish all three types of change? Similarly, the barriers, too, must be clearly diagnosed.

The next step in this analysis is a consideration of the behavioral consequences of grasping and giving aspirations as they are related to the means employed in achieving the goals. It has been hypothesized that what we consider good functioning will result from a blending of the two aspirational orientations. The giving aspirations will act as a control on the grasping aspirations, both softening the intensity of the motivation and, equally important, acting as a control upon the choices of means utilized in achieving the desired ends. As one moves toward either extreme of grasping or giving, deviations either in individual behavior or distortions in relation to societal goals will result. As aspirations are combined with the social acceptability of the means employed, five behavioral patterns emerge:

1. *Grasping aspirations combined with socially acceptable means.*—Persons in this category are often described as "ruthless but honest," "insensitive but successful," or "someone who will never give you something for nothing." Membership extends to all groups in society and includes businessmen, political leaders, union bosses, to name only a few. In recent years the category has been enlarged to include the status seeker and the organizational man. Social workers seldom are called upon to deal with this group directly unless the individual extends his grasping behavior to his own family and we are asked to deal with the children who are the victims. Perhaps in community organization we have our greatest

[22] Cloward and Ohlin, *op. cit.*

contact with these individuals when we unsuccessfully solicit in united appeal drives or attempt to organize support for social legislation or social reform. Their behavior does not call forth concern as long as the means they use to achieve their ends of money, power, and prestige are socially acceptable. Too often, however, because of their position, they evoke emulation, and still we remain unaware of, or unconcerned about, the value toll they take of the larger society.

2. *Grasping aspirations combined with socially unacceptable means.*—In this group are those with whom society has the greatest concern and on whom it expends its greatest efforts. Resulting from this combination of aspirations and socially unacceptable means are the robber baron, the con man, the criminal, the shady businessman, and many a delinquent. Their orientation is to take from others, and when the means they utilize are unacceptable society rises up in alarm and attempts to control their behavior. There is only a narrow line between categories one and two, and when individuals in category one meet barriers to achievement a shift to the use of unacceptable means is likely.

3. *Giving aspirations combined with socially acceptable means.*—The individuals in this group usually create more problems for themselves and for their immediate families than they do for society. Examples of this type include the self-sacrificing artist, the religious ascetic, the martyr, and the scorned prophet. These people often provide society with its scapegoats, but they also mobilize guilt in relation to our grasping aspirations. Historically, they too provide models for aspirational identification, and it is often their extreme behavior and convictions that move societies to become more civilized.

4. *Giving aspirations combined with socially unacceptable means.*—Within this category are found many neurotics, such as the drug addict, the alcoholic, the homosexual. Included, also, are the beatniks and the left-bankers who create their own societal norms as a means of pursuing their giving aspirations when they are disapproved of by society.

The individual personality dynamics of the persons in these four categories show much overlapping and similarity. This is not

contradictory, for this analysis of one of the diagnostic dilemmas has tried to explain why two people with the same personality dynamics will choose different behaviors or symptoms through which to express their conflicts. The analysis suggests that the intervening variable might well be the aspirational orientation of the individual. A grasping orientation encourages acting out in relation to others while a giving orientation supports the internalization of the conflict and the acting out on the self.[23]

5. *Lack of aspirations.*—The members of the fifth group can be described as anomic, lacking in motivation and aspiration. Life to them offers little, and they have come to hope and strive for nothing. Their behavior takes two expressions. The first is complete apathy and aimlessness. The second is that of being "victims" of their biological drives as seen in impulsive and unpredictable behavior to which one is unable to attach reason or purpose in aspirational terms. Their normlessness and valuelessness make them nonproductive members of society. These persons are found most often at either extreme of the socioeconomic scale.

An abstract description of the importance of aspirations and of their deviations is of limited use to the social work practitioner as he thinks in terms of "What do I do about it?" unless we add some consideration of what factors influence the formation of aspirations. What has been described thus far is a model which has applicability to all segments and groups within our society. The diagnostic problem for the practitioner is to determine what factors influence the development of a giving orientation or a grasping orientation or some blend of the two. And, as is true of most human behavior, a variety of related variables must be considered.

As we have indicated, lack of satisfaction of basic emotional needs early in the infant's life can affect aspirations. But this alone will not explain the variety and extent of the deviations with which we come into contact. We must look further to the effects that the value system of the family, the peer group, the cultural subgroup, and the larger society have upon the individual. But even this is not enough, for it is implied in such an analysis that these systems

[23] Sheldon Glueck and Eleanor Glueck, *Unraveling Juvenile Delinquency* (New York: Commonwealth Fund, 1950), Chapt. XVIII. The Rorschach Test material supports this observation in relation to delinquents.

operate independently while in fact they are interdependent. Thus, if the child has received emotional sustenance early in life, he has a better chance to develop a productive blend of grasping and giving aspirations, but he is still susceptible to the influences of the other systems. And it is here that we must be clear as to the differential influences which act upon him. Diagnostically, it is important to assess in psychoanalytic terms the intrapsychic dynamics of the individual, but it is equally important to assess carefully the values and aspirations of his parents, of the peer groups of which he is a member, of the subcultural groups of which he is a part, and of the larger society as they influence the development of his aspirational orientation. In each instance, a particular factor may play a more or less important role, but the diagnosis must attempt to clarify the differential impact of each of these factors. The diagnosis must identify the barriers to development of a giving orientation in each instance—barriers which prevent the individual from perceiving society as giving to him but which influence him to perceive it as a primitive jungle from which one must grasp and take what he can to survive.

What is frightening, however, is the widespread desire for money, power, and prestige in our society today. The lower-class child may develop a grasping orientation as the only means of survival when he is faced with obstacles to opportunity and a hostile environment, but the middle-class child develops a similar orientation, for perhaps different reasons; and neither will produce a "good" society. Unless the middle class takes on a more giving orientation, the lower classes will only become lower.

Social work as a profession is committed to carrying out interventions aimed at changing aspirations. Within our value system we speak of the dignity of the individual, the right to self-realization, encouragement of creativity, responsibility for our fellow men, education for citizenship, and so forth. These are all aspirations which are included in the giving orientation. Thus, social workers must take some responsibility in dealing directly with the aspirations of their clients. Too often, the tendency has been to concentrate upon the social acceptability of the means which people use to reach their goals and to give little concern to the de-

sirability of the goals. Barriers to opportunity are attacked, and should be, but if the person has already developed a dedication to money, power, and prestige, we may provide only temporary satisfaction. The limitless nature of man's aspirations will again create tension, restlessness, and dissatisfaction. The attack on the obstructions to economic opportunity must be seen only as the first step, the meeting of basic needs, but we must at the same time provide growth opportunities in relation to the development of giving aspirations. I am not advocating that we help people to be satisfied with their place in life; rather that they be motivated and helped, not only to achieve some satisfactions for themselves, but also to assume a degree of responsibilty to help others. The achievement of material gain, power, and prestige alone will not assure this goal.

Interventions aimed at providing better means of achieving one's aspiration will focus heavily on the educative process. To affect the aspirations themselves, however, will necessitate techniques of reeducation. Greater amounts of time will need to be invested and more basic dynamics will need to be affected. But where are the points of leverage? Where can we enter the system to bring about change in basic orientations?

In order to answer this question, it is essential that the situation be accurately diagnosed. First, the relative importance of the individual dynamics, the peer group, the subculture, and the larger societal norms must be assessed. Second, the barriers which stand in the way of the development of a giving orientation must be identified. And third, the access into the various systems must be understood so that intervention strategies can be planned. But the goals of aspirational change must not be lost sight of, or the interventions may be too feeble or of too short a duration. It is likely that in some situations the point of entry and, eventually, of change will be through individual treatment or group treatment. But as one weighs the relative importance of the family and the culture in a second situation, it may be clear that these interventions are a waste of time, and energy and effort must be exerted at another level. In a third instance, it will be necessary to create an impact upon all these factors if any interventions are to be successful. We

have been guilty in many cases of evading a careful diagnosis and have instead intervened in a predetermined, patterned way and blamed our failure upon lack of staff or funds. But are we using available funds effectively? Have we taken time to understand the dynamics of the situations with which we must deal? Or are we continuing to promote services which are helpful to those people who least need our help?

It is likely that interventions aimed at all these factors will be necessary. Empirical study and the accumulation of experiences will help to clarify and assess further the specifics of the where, when, how, and the effectiveness of the approach. But one thing remains. The problem is a crucial one, and social workers must take increasing responsibility for its solution.

Round-the-Clock Emergency Psychiatric Services

by ELEANOR CLARK

SOCIAL WORK AS A PROFESSION will face many vital questions during the next few years. Among these will be how to use our relatively limited resources to provide for the enormous and varied needs of people in our present complex society. No one answer is acceptable to each of us, and any attempt to solve the problem involves some degree of compromise. Do our values allow us, for example, to devote most of our time and energy to exploration of avenues for primary prevention if this means that in so doing we must neglect the treatable problems from which families and clients currently suffer? Can we afford to direct our limited time toward those problems most treatable in the shortest period, and in so doing neglect those persons with more severe damage who require more of us? Yet the latter group, who consist of shattered, dependent, disorganized families, perpetuate the most severe social dysfunction if their problems are uninterrupted. Certain studies indicate that we serve only small segments of the population and that our practices make us inaccessible to large groups of people, particularly the lower classes. Are we satisfied? Is this what we want? Or are we prepared to experiment with changes in agency procedures and methods of approach which might widen our area of usefulness?

These questions underlie an experiment currently in progress at the Massachusetts General Hospital. We offer an around-the-clock emergency psychiatric service in which the professional team is asked to give comprehensive evaluation and planning to all patients referred to the service.

Massachusetts General is a busy, private teaching hospital. Within recent years the emergency ward has become informally known as the "front door," and its services are available twenty-four hours a day. Though the majority of patients are diagnosed and treated without admission, a small overnight ward adjacent to the emergency room allows for brief admissions when they are needed. The facilities and specialties of the entire hospital are, of course, on call as required.

The charter, granted 150 years ago, includes in it the cornerstone of present-day philosophy. The visionary men of good will who conceived the idea of the hospital also planned the hospital as a refuge for the sick or injured social outcast or the stranger to the port of Boston. They had in mind specifically destitute merchant seamen and prostitutes. With all of modern medicine's scientific advance, the original commitment remains and is especially in evidence in the emergency ward's activities.[1] As a result, patients come with every degree and type of illness, with or without the ability to pay. Some are brought by relatives, some by agencies, doctors, or the police. On the average, 140 patients are seen during any given twenty-four-hour period in this one facility of the hospital. When the emergency service was instituted it dealt primarily with life-or-death situations. In recent years this is no longer true. Approximately 50 percent of the admissions are now social or psychiatric problems rather than medical.

For the past thirty years a psychiatrist has been available. In 1952 the psychiatrist saw about 300 patients a year in the emergency ward. This number has risen annually; currently we are seeing that many each month. As psychiatric clinics, private psychiatrists, and social agencies have become more appointment-oriented and waiting lists have grown, people in distress have learned of this open door and use it freely. As the number of patients mounted, additional psychiatric personnel was made available, and by 1959 a psychiatric social worker was on call. This step was taken because patients presented so many social problems intertwined with their psychiatric disorders that the psychiatrist

[1] Ellsworth Neuman, M.D., "The Nature of a Teaching Hospital," unpublished Lowell Lecture, Boston, April, 1963.

was hard pressed to provide adequate care. For instance, if a young mother required hospitalization the social worker's assistance in planning for the children was often needed.

Since 1956 several studies have been carried out to examine the results of psychiatric work done in the emergency ward. A study of the patient population by Drs. Chafetz and Mendelson [2] examined the management of one group of patients, those with drinking problems. They learned that though 1,000 individuals with drinking problems were seen annually, and told of the possibility of obtaining treatment in the hospital's alcohol clinic, practically none followed through. Furthermore, a one-month sample of 100 psychiatric patients indicated that of 28 who were referred to the psychiatric clinic, only 2 kept appointments. It became obvious that we failed to provide as open a door as we thought, and we began to examine our philosophy, our procedures, and the patient population.

In 1959, with the assistance of an NIMH grant,[3] we undertook a research project based on the hypothesis that persons with severe alcoholic problems could be motivated for treatment if continuity of care were provided by a staff prepared to meet whatever needs the patient presented. Our procedure involved accepting the first twenty patients arriving in the emergency ward each month who were designated by the senior medical resident as alcoholic. Every alternate patient was designated a control patient and received the routine care of the hospital. Those in the research group were met by a psychiatrist and social worker who instituted a study of the patient and his family and simultaneously offered help with the problems he presented, whether these were requests for help with medical care, food, shelter, employment, marital difficulties, or severe psychiatric disorders. The same team worked with the patient throughout the contact. It is evident that such an approach would rely heavily on the particular skills of the social worker. His duties included participation in the diagnostic appraisal of the patient and his environment; provision of concrete services, with

[2] J. H. Mendelson and M. E. Chafetz, "Alcoholism as an Emergency Ward Problem," *Quarterly Journal of Studies on Alcohol,* XX (1959), 270–75.

[3] Mental Health Project Grant O M—218, National Institute of Mental Health, U.S. Public Health Service.

a knowledge and use of community resources; and continuing casework treatment of the patient or his relatives.

Over a two-year period, 150 research patients were seen and an equal number of controls. Our results were substantial.[4] In summary, 65 percent of the experimental group versus 5 percent of the control group made initial contact with the clinic; 58 percent of the experimental group versus one percent of the control group continued for five or more appointments in the clinic.

In 1962 the NIMH granted further support to allow us a period for a demonstration project to study the effectiveness of this model when applied not only to alcoholics, but also to the over-all psychiatric population of the emergency ward. In this project we now have social workers on duty from 9 A.M to 9 P.M., including week ends, and psychiatrists on call twenty-four hours a day. We attempt to provide for all patients referred to psychiatry the continuing, comprehensive care which seemed so effective with alcoholic patients.

Patients who present themselves to the emergency ward with an immediate problem, such as physical symptoms masking emotional problems, symptoms of alcoholism, and acute social or psychiatric situations, are understood to be indirectly seeking help with an underlying emotional problem. Though the presenting request to the medical team of the emergency ward may concern the physical symptom, need for a place to stay the night, or pressure to hospitalize an acting-out adolescent, we view the situation as an opportunity to establish a relationship between this patient and a professional worker. This relationship is, in turn, used to assist the troubled person to gain a different perspective of his problem. As trust develops, the anxiety, guilt, or anger mobilized by the internal struggle diminishes, and acceptance of the emotional aspect of the current problem can be gained by the patient. Once the patient can trust sufficiently to reveal some of his underlying difficulties, the diagnostic process can begin. The nature of the service requires that we arrive at as full an understanding as possible in a very limited amount of time. We draw first on the patient's own

[4] M. E. Chafetz *et al.*, "Establishing Treatment Relations with Alcoholics," *Journal of Nervous and Mental Disease,* CXXXIV (1962), 395–409.

story, which can often be supplemented by relatives or by data collected from collateral sources. In arriving at a diagnosis and treatment plan our frame of reference is the psychoanalytic understanding of the individual. In what way have the adaptive mechanisms of the ego failed in the present crisis? What has allowed the more pathological unconscious forces to overwhelm the healthier aspects of the personality?

Simultaneously, we must ask ourselves about the increased pressures from the patient's environment. What critical changes within the family or community structure are responsible for the supportive or destructive elements now converging on the individual's internal resources? Our task in studying the patient is at least threefold. We are presented with a patient, for example, who may view his problem as one of physical pain though the findings of organic studies are entirely negative. First we are challenged to help this individual to accept a different concept of the problem which threatens his defensive structure. Assuming that pain has arisen as a defense against great anxiety, the patient will inevitably meet the physician's diagnosis that it is not organic in nature with some degree of resistance. He may display anger, fear, and a wish to flee, or perhaps guilt, self-depreciation, and depression. The task of the psychiatric team then lies in understanding these feelings, offering an immediately supportive relationship out of which trust can develop and the threat may diminish. This often implies relinquishing our previously held convictions about the degree of motivation or capacity to look at himself which is necessary if the patient is to be able to use help. The patient is often unable to communicate verbally in our usual sophisticated manner, and it is up to us to understand his system of communication. One person may need to be fed to learn that we care; another may only respond to careful confrontation with his problem. It is the responsibility of the professional to find a way of offering help that is acceptable to the patient, who is not motivated in the traditional sense.

Let me cite a pertinent example. William, a twenty-eight-year-old man, was referred by a surgeon. The patient had been brought to the emergency ward after being hit by a car. He was not badly

injured, but the surgeon became concerned when he learned that the man had been involved in a series of "accidents." The patient saw no need to consult a psychiatrist, yet he talked of flirting with death. Once, driving 80 miles an hour, he had been severely injured when his car hit a telephone pole. Despite a spinal fusion resulting from this accident, he skied and once swam so far into the harbor that Coast Guard rescue was necessary. Shortly before the earlier admission his marriage ended in divorce. On the day of admission he had been excluded by his former wife from his older son's birthday party.

In long and careful interviews on the occasion of this admission, the patient was confronted with the self-destructive meaning of his behavior. Though he first stated that he tried to avoid the car, he finally admitted that he had stepped in front of it. He then showed openly the depressive feelings his behavior had been geared to handle and accepted the plan for help offered by the service.

If we have been successful in helping the patient to feel less fearful, to acknowledge the role of his underlying emotional discomfort, and to trust us to help, our first step has been accomplished. We are then faced with the task of understanding the nature of the internal conflict that underlies the symptoms and the predicament in which the patient finds himself. Our first tool is the interview with the patient.

Most crucial in the patient's social environment are his relationships with key persons in his life. Often the meaningful clues, particularly in the diagnostic appraisal of very disturbed persons or young people, are gained from interviews with those closest to him. The involvement of crucial persons at this moment of crisis also has other, often far-reaching implications. Frequently, the future course of treatment hinges in large part upon the modification of attitudes of these key persons. If a spouse requires hospitalization, for example, this step may be the crucial one in the process of alienation, and the period of hospitalization may result in the final breakdown of family. On the other hand, careful handling at this moment may reduce alien feelings and mobilize the capacity to follow the patient through this difficult experience without undue

disruption. Occasionally, this can be the beginning of a shift in attitudes leading to greater understanding and healthier relationships in the future.

Finally, the diagnostic appraisal includes the use of information gained from the community, the police, local doctors, hospitals, law-enforcement facilities, and other agencies. The information gathered through these contacts often adds greatly to our understanding of, and capacity to plan for, the patient. More important, however, is the help these persons can offer in providing the support needed to carry out future planning for the patient. Often the involvement of a local doctor, probation officer, or school guidance counselor at this point encourages his continued interest. When they are given guidelines that grow out of their joint appraisal of the patient, and are assured of the future help and interest of the psychiatric team, these professionals frequently continue with less anxiety, more interest, and greater understanding of the meaning of their supportive role.

Obviously, the diagnostic period is both the beginning of treatment and a demonstration of its potential helpfulness. We try to offer a program of treatment that is individually tailored to meet the patients' differing needs; for we are clearly aware that only a few of these patients would benefit from the usual type of psychoanalytically oriented psychotherapy or casework.

It is, however, our philosophy that if a patient does not fit our usual mode of working we will not fall back on a prognosis of "untreatable," "unmotivated," or "hopeless" until we have attempted other approaches—old and new—which may restore previous functioning, or achieve improved adjustment for this particular person.

Many of the patients referred to us suffer from severe psychiatric disorders and complicated social problems. We come to know them in the late stages of their illness, and as is true of many severe chronic physical illnesses, a cure is not possible. Nevertheless, we try to restore that degree of functioning which has been recently lost, or to establish the best level of functioning that is realistically within the patients' capabilities. I believe this point of view to be very important both for the patient and for the professional person

who works with the severely ill. If unrealistic expectations are held but not reached, the patient endures fresh disappointments, and the narcissistic blow to the therapist may create disappointment and anger which endanger the therapeutic relationship.

Let me describe the work on behalf of a severely disabled patient for whom our professional responsibility was essentially that of management. A sixty-six-year-old Greek woman was brought by her daughter, a psychologist. Mrs. L. had returned from a visit to Greece five days before. In Greece she felt limp, empty, and depressed. The family history revealed that a previous trip to Greece in 1955 had been occasioned by her sister's suicide, and while she was there her husband had died. The current depression seemed to be a reactivation of these earlier losses. On her visit to the emergency ward she presented a classical picture of depression, including self-accusatory delusions. Her son and daughter would not under any circumstances consider hospitalization although the doctors thought it to be the safest course. Interviews were made more difficult because Mrs. L. spoke little English.

Though we were concerned about the severity of the depression, medication was prescribed, and Mrs. L. was placed in a carefully supervised and supportive nursing home within walking distance of her daughter's crowded apartment. Interviews were arranged with the doctor and social worker, and the nursing home was assured that we would help at any time—night or day—if need be. Four weeks after she went to the nursing home Mrs. L.'s depression lifted, and she returned to her son's home. She has subsequently had monthly checkups, and her symptoms remain in remission. Careful, intensive, efforts with Mrs. L., her son, and her daughter helped this elderly patient through a critical period. Her defenses restored, she now maintains her pre-illness equilibrium.

Another group of severely damaged patients can be helped by continuous treatment if it is fashioned to meet their individual needs. An interesting experiment in group endeavor was tried with a group of homeless, unemployed, isolated men who had long-term histories of chronic alcoholism. They were alienated from their families and usually described as "skid-row" alcoholics. Though initially responsive to the research team's reaching-out efforts, they

withdrew and became frightened when a continuing one-to-one relationship was pursued. Their gross, early deprivation had left them with a primitive view of life and its interpersonal relationships. We recognized that their needs for human contact and ego-building experiences could not be met by the usual community contacts and decided to structure a specially geared substitute family and small community around them.

We labeled this group therapy endeavor the "supper club." A psychiatrist and a social worker invited the patients to join in a discussion to determine whether a group was wanted and, better yet, what type of group might be indicated. A few wanted to discuss problems, some wanted a more social get-together, and some wanted what they called a "cocktail," or mixture of the two.

They wisely chose the mixture. It was agreed that once a week the doctor and the social worker would meet with the patients in the hospital cafeteria for dinner. Following this, over coffee and dessert, the group would discuss their problems. At first each patient related to the leaders as a child to his parents or a student to his teachers. One would ask a question about physical damage caused by alcohol, and then another would raise a completely unrelated question. Their feelings were not expressed in these discussions. However, intense feelings arose over the kind of doughnuts or cookies to be served, a reflection of their oral preoccupations. The secretary who provided "oral supplies" was instructed weekly about where to find the best doughnuts. She followed the instructions to the letter. Meanwhile, the leaders gave a great deal of themselves and entered into discussions actively. In addition, if a patient needed medication or hospitalization the leaders took care of it. They held individual interviews between sessions as required. At his first visit each member gave a carefully limited two-minute autobiography and drinking history. The leaders did the same.

Gradually, the patients began to plan the menu, and eventually they took over all the planning. A hospital dietitian became a central figure—giving but limiting. If a last-minute switch was requested, the doughnuts had to be returned and cookies and ice cream substituted. The content of discussion also began to shift.

They began to reveal their feelings and shared ideas and experiences with each other, not only with the leader. This carried over into friendships on the outside. When a patient demanded hospitalization and the doctor hesitated, the other members waited in the hospital lobby, on a sit-down strike, until the patient was settled. The leaders were consistent in never allowing one member to be made the scapegoat and in avoiding long exploratory confessions. Discussions, in which emotionally charged material was safely displaced, were encouraged.

Gradually, the group members gained pride and self-esteem. One found a civil service job and encouraged the others to try. Now, almost three years later, all of the ten regular members are working, they have addresses, some are reunited with their families, whom they brought to the last Christmas party. The group welcomes new members and visitors, for they feel that they have something to teach about recovery from alcoholism.

These cases are typical of many that we see, and are examples of patients who need care but are in the late stages of an illness. It is also our aim to reach patients in the early stages of emotional illness and those in danger of becoming ill because of threatening life situations. Our immediate accessibility helps to achieve this goal. The following case is illustrative of this group.

Mrs. S., a forty-two-year-old mother of seven children, came to the emergency ward one evening a year ago because of a badly cut hand. The surgeon, while stitching her hand, noted her intoxication, inquired a bit into her difficulties, and referred her to our unit.

On arrival Mrs. S. was guilty, self-depreciative, and, initially, uninterested in our help. She had come to the hospital about her hand. Gradually, however, she related that her husband had died four months before. She had sold their farm in the West and moved to Boston, hoping that her family would help her with her grief and with the care of her children. She had an aged arthritic mother, two alcoholic siblings, and a brother who ran a liquor store. The family offered alcohol as a solution for her depression, and she accepted it. She had not had a problem with drinking prior to her husband's death.

During these few months she had let the apartment go to pieces, the children were not cared for adequately, and her drinking had been constantly on the increase. The doctor and worker who evaluated Mrs. S. decided on casework as the treatment since we hoped to help her to find a healthier way of handling her grief and, simultaneously, to assist with the heavy practical problems of caring for the seven children, the youngest of whom was only two.

Mrs. S. was given an appointment to return to see the caseworker, but did not keep it. The worker made a home visit and found Mrs. S. sober and, though still ashamed of her behavior, beginning to make efforts to pull herself together. She accepted further appointments and began regular casework interviews. To our knowledge she has done no further drinking since the visit to the emergency ward. The casework focus has been on bolstering her self-esteem. The worker has been active in taking care of her through arranging medical appointments and assisting her to deal with the many reality problems in her life. She was helped to clarify her finances, and some of the children were sent to summer camps. Interviews have been carefully geared to handle her grief with a view to her need to function at her best possible level so that her depression will not unduly disrupt the children's development. For the most part, her feelings about her loss have been dealt with indirectly though she has cried and openly grieved to some extent. Much of the work is focused on the oldest boy, now sixteen, whom his mother identifies with his father. He has acted out some of his discomfort and is also receiving help.

If the referring surgeon had been less perceptive we would probably not have seen this woman until the effects of her drinking and the unresolved grief had intruded enough into the care of the children that the school or an agency like the Society for Prevention of Cruelty to Children would have had to take action. This family has done quite well in a relatively short time. Had many more months gone by, Mrs. S.'s illness would have been more difficult to treat and the effects on the children more destructive.

Among the 3,000 patients whom we see annually every degree of pathology is represented, and our approach to patients is flexible. Our goal is to attain earlier referral of patients who are in danger

of emotional or social breakdown. Our unrestricted intake, immediate availability, and work with the other units of the emergency ward are directed toward this. As the other services know us better, they begin to look more carefully at the symptoms which mask underlying emotional problems and are more likely to refer patients in the early stages of emotional illness. We are also convinced that if we are prepared as professional people to introduce greater flexibility of admission procedures and methods of treatment we can help patients of varied degrees of illness, including those who are quite severely ill. This involves giving up many of the traditionally held systems of procedure, measures of treatability, and goals of treatment. Our program offers obvious avenues for tertiary prevention and opens the door for secondary prevention. As we discover more about the early stages of illness and contributory factors we may offer some findings which will be helpful in efforts toward primary prevention. For instance, we are currently planning research aimed at the study and treatment of children of alcoholic parents. We are particularly interested in the effect of a parent's alcoholism on the growth process of the child. We hope to make some progress in understanding the pathological effects and the development of resistance factors. We also plan a program aimed at the early recognition and treatment of adolescents who show tendencies toward the pathological use of alcohol. Specifically, we will study teen-agers following their first arrests for an alcohol-related offense.

Many intake practices operate to select those patients whose intelligence, ego strengths, and motivation fit them for psychoanalytically oriented psychotherapy or casework. In our society people need psychological help for problems of all kinds, of greater and lesser severity. This involves the provision of many different types of treatment, including the more traditional ones, which are effective for a large group of patients. It also involves experimentation and flexibility to include the groups who are unable to profit from conventional methods of treatment. Many such experiments are going on in work with delinquents, with new forms of mental hospital treatment, and work with multiproblem families. These are purely experimental, however, and many of our present ad-

ministrative procedures and interviewing methods tend to exclude a large group of people.

In Boston, this past year, the United Community Services undertook a mental health survey.[5] Certain features of this survey replicate others undertaken in various parts of the country. Most interesting here are the findings from a sample of ninety-five cases studied to determine whether or not referral was successful. Two thirds were unsuccessfully referred from the United Community Services to an appropriate agency of the community. When the high rate of unsuccessful referrals was analyzed, certain features were particularly striking.

Of twelve people with child- or adolescent-centered problems, only one was successfully referred. Of eighteen requests for help with separation or divorce, only two followed through their referrals. Only one of eight illegitimately pregnant girls was successfully referred. Similar to the findings elsewhere across the country, lower-class status correlated highly with unsuccessful referral. It is clear that middle- and upper-class values, educational opportunities, and incomes lead individuals more readily to identify disturbance as an intrapsychic problem. Persons with less opportunity are less informed, more of their energies are consumed with "making ends meet," and they are more apt to approach an agency with a definite request. Yet agency practices often require these needful people to travel to the center of a complicated city in order to apply for help. They may have to endure a waiting period, or may be given a definite appointment which perhaps they cannot keep because of the many crises likely to occur in their lives. If the appointment is not kept and they have no telephone, it is unlikely that initiative will be taken by the agency to resume the contact. If the client is able to meet all the requirements he is then expected all too often to enter into an examination of the intrapsychic problems that have led him into his predicament before anything is done about the symptomatic request. If the client feels sufficiently misunderstood after all these maneuvers he is unlikely to return.

As agency executives and caseworkers we must examine our

[5] William Ryan, unpublished report of the Boston Mental Health Survey, 1962.

policies and beliefs and offer more service at the point of contact with patients, if we want to extend our help. This requires greater understanding that the presenting problem must be understood as the client's felt need and be taken seriously. We need also to reach below his surface expression of need to find ways to help with the underlying emotional problems. This implies greater use of reaching-out techniques. Specialization of agency function also deserves scrutiny. It is difficult enough for a reasonably well-trained social worker to find the proper resource in a community. How can we expect an anxiety-ridden client to do so?

To draw an analogy from medicine—each of us endorses wholeheartedly the attempts of the scientists to discover the causes of malignant growths. Yet we are not critical of medicine's efforts to treat or to relieve the severe pain of the person suffering from cancer. We also know that if malignancy can be discovered early enough, the disease can be cured or arrested, and this secondary prevention can often offer the patient a full life expectancy. Malignancy, however, has a sneaky way of developing and often does not show itself until the disease process is well advanced.

The medical personnel who give relief from the pain of terminal cancer, who work in early cancer detection, or who strive to find the causes of the disease are all greatly esteemed. Is there not a parallel in social work today? It seems to me, that we have a manifold obligation. Our responsibility is to manage, rehabilitate, and treat the ill person with our eye always on his capacity to function in a social world; to intervene as early as possible to prevent the full development of disease and social malfunction, and to examine the social, cultural, family, and intrapsychic processes that are causing emotional and social malfunctioning. This implies the inclusion in our conceptual framework of all points of view. It is my own philosophy that basic to all is the understanding of the internal economy of unconscious drives, prohibitions, and defenses with full and increasing appreciation of the adaptive mechanisms of the ego.

Diagnosis and Treatment of Brain-damaged Children

by RAY O. CREAGER, M.D.

IT IS CURIOUS THAT PSYCHIATRY, which has in the past invented such esoteric terms as "oligophrenia," "altrigenderism," and "thymergasia" has not devised a more sophisticated term than "brain-damaged." Some writers have substituted the term "brain-injured," and "hyperkinetic" has been used for a subgroup of symptoms. In truth, brain damage may sometimes be the result of developmental abnormality or even of malfunction without specific damage. On the other hand, not all injury to the brain causes this syndrome. We shall use the term "brain-damaged" because others have set the pattern for us, rather than because we think it is desirable.

In this discussion we shall consider a syndrome usually described in children, characterized by certain behavior disorders, problems in the development of learning, perception, and in many other areas of ego functioning. We are not considering the disorders that are usually included in cerebral palsy, where there are specific neurological changes, although some of the same ego defects may appear with cerebral palsy. Neither are we considering many of the mental defectives, although mental deficiency can occur when there is brain damage. There are many similarities between these children and those we call "primitive" in our clinic slang wherein the development of the personality is impaired in many areas by emotional and physical deprivation. Childhood schizophrenia needs to be differentiated also.

The brain-damaged child shows changes in behavior in infancy. A mother often reports that her child was a fussy, crying baby who

slept very little. Feeding and colic problems are common. The child may be a head-banger or display various rocking motions. He is noticeably hyperactive as soon as he begins to walk. Coordination difficulties appear very early, and he tends to be slow in walking or developing reciprocal motion in his walking.

In the prekindergarten period this child is more prone than the average to develop autistic habits, in which he withdraws and seeks satisfaction within his own body. Thumbsucking or masturbation may be pronounced and persist into the elementary school years.

The symptom picture becomes more clear as the child goes into his school years; typically, he may be referred to a child guidance clinic when he is between six and nine years of age. There are variations in this picture. The "brain-driven" syndrome is common. Then we have the child, sometimes called "hyperkinetic," who seems to be driven by an internal force into constant activity. His attention and interest flit rapidly from one thing to another. He is aggressively curious. Destructive activities are common. He may tear the head off a doll, for instance, not so much to destroy as to see what the doll would be like without a head. He is impulsive to an extreme and he relishes excitement. When stimulated, as by muscular activity, his excitement spirals and feeds upon itself until it may approach ecstasy. He may express wild, poorly developed fantasies of gory catastrophes. He may be preoccupied with various autistic interests, such as water and plumbing or electricity.

This is not the only symptom complex we see with the brain-damaged child, but its components are present to some degree in the course of development of most children with this disorder. It is more prevalent with boys than girls. Hyperactivity tends to diminish in intensity as speech becomes more fluent and maturation occurs.

Speech disorders are common in the brain-injured child. Immaturity of speech is common. Tongue coordination may be impaired. The disorders of the mechanics of his thinking, which are a basic problem for this child, are of course reflected in his speech. Perseveration occurs. He is not capable oftentimes of sustaining any spontaneous expression and speaks in short bursts of intensity.

He may ramble, or his verbalizations may be completely disconnected. In fact, the loss of continuity of all expressions is a central characteristic of this disorder.

Continuity of visual perceptions is disrupted also. The brain-damaged child sees the trees and not the woods. His reception of visual images has been compared to the picture we see when our television set is out of order, being a hash of miscellaneous stimuli. He cannot determine the degree of angles and space relationships properly. When he tries to reproduce the images he sees he may turn them sideways or upside down. He may distort them and even if he recognizes the distortion be unable to correct it.

His perception and awareness of his own body are damaged most of all. Our ability to orient ourselves, to guide our bodies in their functions, to make judgments about ourselves, is dependent upon an unconscious image of our own bodies. With an inadequate image, coordination and integration of functions of self are impaired, self-confidence is lacking, and we have difficulty in understanding and anticipating our fellow human beings. A defective body image is characteristic of the brain-damaged child and is a major cause of his anxiety.

He has other causes for anxiety, with impairment of his abilities to evaluate his environment, to make judgments, and effectively to express his needs. His attention span is very short. Oftentimes he is smaller in stature than other children. His musculature may not sustain a contraction, so that when he squeezes anyone's hand it is with a milking motion rather than a constant grip. His gait often lacks a definite pattern, so that there is no characteristic rhythm to his walk. In fact, he does not form many of the little habit patterns of posture and movement that allow the average person to move about without really planning each motion.

With all or even some of these difficulties, it is really not surprising that the brain-damaged child has difficulty in school. His poor social adjustment often makes him the scapegoat of other children. His short attention span and hyperactivity make learning nearly impossible at times. His inability to express himself well verbally or in written material, his inability to control his own thoughts, and his impulsiveness all contribute to school problems.

In a permissive classroom, on an unsupervised playground, or in a poorly disciplined school bus he may lose all ability to control himself.

Reading problems in particular often occur. The brain-damaged child may be completely unable to read, or he may just be behind the expectations for his chronological age and intelligence. His reading may be mechanically adequate, but he is unable to absorb or learn from what he reads.

Reading difficulties particularly seem to be associated with handicaps in speech or perceptual functioning. They occur much more frequently in boys. When, for example, a five-year-old boy who shows some symptoms of a brain-damaged behavior syndrome has a history of speech that was late in developing, it is wise to expect that he will have trouble with reading. This anticipation may enable teacher and parent to take precautions, such as providing individual instruction, which will forestall trouble later.

The intelligence of the brain-damaged child causes some confusion in the minds of parents and teachers. Testing and observation may indicate an intellect that is average or better than average. Careful testing by a trained psychologist will reveal an unusual amount of variation among his various abilities. Conceptual thinking may be defective, with the child able to reason in concrete terms but not in abstractions. A knowledge of these hidden weaknesses can enable the teacher and parent to modify their expectations to suit the child's real capabilities.

We need to recognize a handicap that exists within the people who are to help this unfortunate child. We have already mentioned his lack of social sense and his relations with his schoolmates. Adults do not find him likable either. To understand why this is so, we need to delve a little, to understand ourselves more. In the process of maturation, we have all struggled with the primitive desires that are so readily expressed by the brain-damaged child. We have developed defenses against randomly expressing aggression, against venting curiosity without restraint, against regressing into autistic activities like masturbation. We generally dislike a person who threatens our self-restraint. The threat from the activities of the brain-damaged child is to such basic defenses

that our dislike seems almost instinctive and is particularly difficult to handle.

Immediately, once we realize this, we can understand the plight of parents. Often we find signs in our social history of strong feelings of rejection in parents of the brain-damaged child, although they also sincerely love their child. Added to this are the constant concern and watchfulness he requires. As one mother said, "From the time he was one year of age we have had to watch him constantly. We never know what he will do next." Of course, the parent does not get too much opportunity to gratify parental pride, since this extension of his own image is the cause of so much trouble. The worker who interviews these parents could be misled by the old aphorism about "problem parents." It is important to realize that this child can place an intolerable stress upon the adults who live with him. The family of the brain-damaged child may become sick too in response to this stress.

One of the patterns of interaction that can fool the caseworker is that of the good sibling who is secretly aggravating the brain-damaged child's problem. The angelic child knows well his sibling's susceptibility to stimulation and deliberately triggers him into some aggressive, acting-out activity; the parents do not recognize what is happening. The motivation for the good child may be to express his own hatred for the brain-injured child, or he may get vicarious satisfaction from his sibling's doing the things he would like to do. The worker may get the first hint of this pattern when somehow an improvement in the behavior of the brain-damaged child is achieved and the mother reports that her good child—who thus has been deprived of his vicarious outlet—suddenly is showing bad behavior.

Another subtle pattern of family sickness can be called the "deformed-child" reaction. We are familiar with this pattern as it is seen in some families of children who are crippled or deformed from birth. The parents are threatened by this deformity of the extension of their own body images. They react to the threat by denying the existence of the deformity. The child is indulged in order to aid denial of rejection. The child follows the parents' leadership by denying his own defect. I well remember a teen-age

boy who had 20-400 vision in both eyes but refused to acknowledge his blindness and insisted upon driving a car. His parents, who had denied the existence of the handicap for many years, would not stop him. Such parents overprotect their children and project responsibility upon others for the problems that result from the handicap.

On first thought, it is hard to see how the deformed-child reaction can occur when there is a brain-damaged child since there is no obvious crippling. This can be better understood if we realize that the parents of such a child have perceived a difference in him from birth. (One author has entitled a book about these children *The Other Child*[1] in recognition of the fact that adults do recognize a nebulous difference about the brain-damaged child almost from the day he is born.) The subtle character of this difference makes denial of the problem easier. In our experience we have often seen the deformed-child reaction in fathers, who can escape by prolonging their working hours and who state that the child is just "all boy." The mothers, who stay home with the children, are more realistic in their appraisal and want help. Serious marital conflict sometimes results, and getting paternal cooperation with planning is a major difficulty in this situation.

A problem child of this sort brings out the immaturities of his parents. As a result, emotional sickness can occur, in almost any form, in a family that would otherwise make a satisfactory adjustment. The child too is more prone than the normal youngster to develop emotional illness. His ability to tolerate stress, with the weaknesses of ego function that we have mentioned, is low. His difficulty with introspection eliminates a primary protective device. He sometimes cannot recognize and define his own anger or sorrow in response to simple trauma.

The parents of these children have a prime requisite for successful treatment. They want help very much. The children often want help also if the offer is presented in terms they can understand. I remember the little boy who told me pathetically, "I want to be good but I can't stop myself." Children who have convinced

[1] Richard S. Lewis, *The Other Child: the Brain-injured Child* (New York: Grune and Stratton, 1951).

their teachers that they care nothing about reading or other learning break down in tears when they become convinced that the teacher understands and will try to help.

Our trouble in the past has been that we did not have the right skills to give them help. The permissive interview that encourages free expression, with the interviewer focusing on unconscious conflict, may leave the child overstimulated and upset and the caseworker confused or off on a tangent. Parents who try to follow suggestions gleaned from magazines or from their neighbors find that truly love is not enough. The schoolroom that tries to encourage creative thinking by permitting random activity finds the brain-damaged child spiraling into intolerable excitement.

Since the newer techniques do help many of the children we see, the first step in planning an appropriate treatment is to differentiate the brain-damaged child from those who have other disorders. A child who has all the symptoms we have mentioned can be spotted by an experienced receptionist while he is in the agency's waiting room. However, as we emphasized initially, the symptoms of this disorder appear in various degrees at different times in the evolution of the personality, and secondary emotional problems may disguise the syndrome of brain damage. The diagnosis should not be based on a single symptom but on a composite of symptoms and the history of typical symptoms throughout the child's development. Some writers emphasize the importance to the diagnosis of a history of some trauma prenatally, at birth, or postnatally. Our knowledge of such causative factors is growing rapidly. Virus infections or toxemia in the pregnant mother, complications of the Rh factor, breech delivery, prematurity, multiple pregnancy, prolonged pregnancy, prolonged anoxia of the newborn, and serious infections, particularly of the nervous system or lungs of the infant in the first two years, have been blamed for brain damage. It is, in fact, felt that one of the reasons we are seeing more brain-damaged children now is that medicine has advanced to the point where the infant who previously would have died as a result of such afflictions is now saved.

The electroencephalogram may help, but it should not be used as a primary basis for the diagnosis as a rule. The classical neuro-

logical examination has to be modified to put new emphasis upon coordination and over-all patterns of mobility if it is to be significant. The greatest help usually comes from the combined studies of social worker, clinical psychologist, and child psychiatrist.

The most difficult disorder to differentiate is that of the neglected, primitive child. A child who has been so deprived and mistreated as to demonstrate this syndrome has not been given the emotional support needed to develop the basic elements of his personality, and he can have most of the symptoms we have described. However, the perceptual handicaps and the irregularities of the psychological results are more pronounced in the brain-damaged child. The neglected child shows coordination difficulties resulting from lack of practice and poor physical development that are more gross in quality, not apt to involve fine motions, and not so apt to involve reciprocal motion. The history will not show the signs of difference in early life seen in the brain-damaged child.

The childhood schizophrenic is difficult to recognize. There is more autism, and withdrawal is oftentimes a primary characteristic. The schizophrenic may be more inept in evaluating or responding to his environment in that he may not be able to differentiate things from persons, may be mute or totally incapable of verbal communication, may distort what he sees by intermixing his fantasies with reality. It is felt by some workers, however, that brain damage is the basic causative factor for childhood schizophrenia, and some of these children, as we watch them develop, do show progressively more signs of organic trouble.

The study of ego function, or the child's ability consciously to perceive, evaluate, and react to his environment, is basic to our diagnostic thinking and to planning therapy. Since the brain-damaged child cannot control, cannot tie together the loose ends, he needs help. The adults in his environment must provide strength for him until he can develop his own. The keystone to therapy here is structure.

The structuring of his environment involves creating regular patterns for the child's daily life. Routines are created in the home life so that decisions are minimized and habits are created. Discipline is kept simple and direct. It must be consistent, firm, and

administered without temper. Temper explosions in the parents are like kerosene on the flames of the child's emotions. Nagging and prolonged explanations by parents are undesirable. With this child's difficulty in communication he often feels that others can outtalk him, that his feelings are being submerged in a deluge of words. He does not understand subtle values, and rules for him are better reduced to black-and-white terms rather than gray. Preventive planning by the parents may avoid the need for much punishment. Any activity or situation that will overstimulate the child should be shunned. Demands upon the child should be reduced to the level of his maturity, with full recognition of his emotional immaturity. This child, like any other, needs to be proud of something and to feel that he pleases others. Finding areas where the child can accomplish and cultivating these can be helpful. Of course, he needs love too. Simple social situations, with one or two playmates in a controlled setting, may stimulate his growth whereas an undisciplined large group is bad for him. Wrestling and fighting should be avoided, although he may seek out these activities. He may develop coordination and indirectly reduce his anxiety by any activity, such as dancing, that helps him to incorporate rhythm into motion. Playing records may be very soothing. Soaking in a tub of water may be pleasant for him and give his mother a welcome rest from the care of a small brain-driven child.

It is obvious that this program requires the mother to give all her energies to the child. She will often surprise the worker, however, by the degree to which she seemingly will submerge her own needs in order to help the child. Probably the establishment of a routine family existence, as is necessary in these cases, gives relief to the total family anxiety. Relief of pressure from the child helps parents to sustain their efforts.

Our knowledge of the use of new medicines for this disorder is growing rapidly. It is important to know that tranquilizers and cerebral stimulants bring about different reactions in the brain-damaged child than they do with adults. Some of the otherwise useful drugs have little effect on these children. On the other hand, stimulants of the nervous system, such as dextro-amphetamine (perhaps known by the trade name Dexedrene), or methylphenidate

(trade name, Ritalin), seem to calm the brain-driven child. Under such medications he can concentrate better, and some children who take these drugs show a surprising improvement in perceptual abilities. Speech may become more fluent. Marked improvement in school performance may occur. One seven-year-old boy called his medicine his "think pills" because he associated his more effective thinking with the medication. We cannot always predict which of the several new drugs will be most helpful to the individual child. However, our experience indicates that about 80 percent of brain-damaged children can be helped by medicines. Oftentimes the help is dramatic; at other times, dosage or prescription must be varied. The physician needs the observations of parents, caseworker, and schoolteacher in order to make adjustments.

Teamwork among all workers is indeed essential to the treatment of this child. Probably utopian would be a controlled milieu, with skilled workers directing their efforts. This can be provided in psychiatric hospitals for children, and sometimes it is valuable to hospitalize children with brain damage. More often, however, the child is treated at home, and coordination of the work of all members of the team is required. The parents should not be forgotten in this team.

Recently the teacher of a schoolroom for brain-damaged children noticed a positive difference in the response of a number of her students. The parents of these children had joined together in a special group. They had familiarized themselves with the characteristics of the brain-damaged child and with the work that was being done with their children, so that they gained support in their own efforts and were able to coordinate their work with that of the teacher.

Of the elements of therapy, one of the most important is provided by the school. We have been saying that helping the child to compensate is our goal, and emphasizing that conditioning and giving a prolonged opportunity to learn the patterns of adjustment are methods we use. The teacher of the special room adds to these skills by helping the children to overcome perceptual handicaps. Relatively simple procedures, such as reducing most visual stimuli by the use of neutral colors while teaching materials, intended to

stimulate, are brightly colored, are very helpful. Traditionally, instruction of children is intended to stimulate their interest. Here stimulation is carefully controlled and channeled. So that extraneous stimuli and possible spiraling of excitement may be minimized, the room may provide individual cubicles so that each child can have his own study center. Children call these their "offices." Classes are kept small, and each child has an individual relationship with his teacher. Given adequate cooperation from parents, these rooms have enabled children to grow mentally and to learn. The pleasure of a child who has been near expulsion from school in the past, at being able to read and write is very rewarding.

In Kalamazoo, with the help of a dedicated worker at the YMCA, another kind of learning program proved successful. Children attended a group one night a week, and their parents had a monthly semisocial meeting with them. The aim was to help each child to develop physical skills. Since these children had been discouraged by their failure to keep up with their age group in coordinated tasks, competition between individuals was avoided. Instead the child competed with himself. He tried to break his own record at running or swimming, for example. Activities were selected that helped the child incorporate rhythm into muscular exercise. A child in the latency period can achieve much peace of mind through muscular activity, but contact sports that overstimulate aggressive drives should be avoided.

Counseling and psychotherapy for the child's anxiety have a role to play also. We have said that the brain-damaged child is more susceptible to emotional conflict than the average child. He will lean heavily upon the therapist's strength, once a relationship is established. Interview techniques have to be simple, attuned to his social and emotional age rather than his chronological age. Restrictions upon the child's expression are applied whenever necessary. Such things as refusing to spend the interview hour in the playroom when the child overreacts and disintegrates in a play situation, or insisting upon restricting an interview to certain areas when the child cannot control his rambling discourse, may be done. The most important factor is the therapist's ability to empathize

with the child at his level of functioning. While this is particularly difficult with brain-damaged children, it can be achieved with experience, objectivity, and knowledge.

We have tried to emphasize that good diagnostic thinking is essential to good treatment planning. This is the rule for good medical practice, and it can be applied to casework also. Growth of family casework knowledge is gradually producing systems of family diagnosis. One useful way of categorizing family problems is to classify them according to the disordered function of a single family member, when that person's affliction influences the whole family life. The disordered total ego function of the brain-damaged child, involving his mobility, impulse control, attention span, speech, perceptual functions, and ability to think, causes a problem for the entire family as well as for school and community. Helping the child and his family requires the coordinated efforts of a team of workers to provide a structure for his existence, to teach him, to give good medical care, and to help with emotional problems to which he and his family are prone. Knowledge of these children and their problems has grown rapidly in recent years, and areas that have been touched upon here can be pursued further in books and papers by many authors.

Whether or not we do help this child depends basically upon his recuperative powers. Although most of these children eventually make a satisfactory adjustment, not all of them can do so. We can only help; we cannot cure. We can grow best in our abilities if we retain our humility. It is good to remember the words of Ambroise Paré, a surgeon of the French Army, who wrote of his treatment of a wounded soldier in 1537, "I dressed him, and God healed him."

The School as a Group Setting

by VIRGINIA L. CROWTHERS

PEER GROUP ASSOCIATIONS, whether natural groups or structured into agency and/or school programs, have always been an integral part of the basic social structure of schools, both in the classroom and outside the classroom. We could cite a myriad examples: the chumship groups of small boys cohesively cooperating with heretofore flaunted school rules so they can get out at the first possible moment to play ball; the dynamic interaction of the power structure and subgroups in an elementary schoolroom with the rolling up the aisle of apples, oranges, and bananas as the mysteries of peer group communication resulted in that never-to-be-forgotten height of *esprit de corps*—the surprise fruit shower for the teacher.

We have a long history of structured group activities both within the school itself as the extensive extra- or co-curricular approaches have developed, and as various agency programs have been offered at times within the school or related to the school.

There is and has been need to raise fundamental questions regarding the actual experience which individual youngsters have in groups. What about patterns of subtle and not-so-subtle discrimination, not only racial discrimination, but other forms such as the cashmere sweater have's and the cashmere sweater have not's?

What happens inside the members inside the group experience inside the school inside the community? Is the experience helping to maximize their potential development?

A young teacher suddenly discovered a fire in the metal waste-

basket just as the home-room group was about to go off to the auditorium to see an eagerly anticipated motion picture. The teacher's method of handling the situation was first to get the blaze out and then to confront the group with the seriousness of the incident, indicating that obviously the fire had started with the knowledge of someone, or several someones, in the room. She requested that each member of the class write out any suggestion he had as to what to do about the situation, and reminded them that she knew they all were anxious to see the movie. When she quickly looked through their papers, she found on one the words, "Let the class go to the movie, the one who did it will stay behind."

This happened in the early 1940s. The young teacher understood very little of dynamics, either individual or group. She did know that she had a class anxious to get to a movie, a serious safety and value situation on her hands, both in terms of the individuals and of the total group, and a hunch that whoever knew something about it might respond to group pressure, the desires of the class to get to that movie. If such a situation should occur today that teacher would raise many theoretical questions: What did it mean that the boy had such poor impulse control that he set the fire? Even though his own impulse control broke down, what was the meaning of his response to peer group pressure? Was there some form of power-group structure within the class group that may have operated so quickly as to have produced the written suggestion? Might she have been playing into a power-group structure which would settle the score with this boy later? Could the class group have been helped to appreciate the youngster's possible craving for acceptance and a spot in the class status system?

The explosion of the social sciences, particularly with reference to small-group theory and social psychology, has occurred mainly since the 1940s. At the same time, a great variety of forms of using group experience as part of a diagnostic and treatment process has developed. Increased knowledge and sophistication about group behavior have become part of the training of educators as well as of social workers.

It seems clear that delineation of a frame of reference in our consideration of the school as a group setting is preeminently neces-

sary. Such necessity arises from the stage of evolution of the social sciences and the helping professions in which we currently find ourselves. Though much helpful theoretical material has developed, we can say with the poet, "All that's past is prologue"; for, indeed, knowledge about the dynamics of group behavior and systematized methods for teaching such knowledge, as well as the long hard task of synthesizing social psychology with individual psychology is barely to the prologue stage in some respects.

There is now an extensive body of literature and there are specific courses for those who are interested in a thorough grasp of group dynamics in the school setting. Some of the courses may be found within the curricula of social work training. The Center for Group Dynamics at the University of Michigan has been doing extensive work in school settings, at many points involving social workers as well as teachers in research designs to learn more about the dynamics of group life in schools, and developing effective ways to make use of the dynamics for the enhancement of individual and group learning. Possibly Lippitt, Watson, and Westley present the most provocative challenge to all helping professions in their broad concept of client system (individual, group, or community) and change agent (teacher, social worker, psychologist, or other) working in dynamic interaction toward mutual goals of improved functioning of individuals, groups, community, and society as a whole.[1]

This concept probably points the way toward which we are steadily moving—the helping professions sharing their knowledge and skills in order to achieve the common goals of a truly human and humane society. Meanwhile, while we are confronted with the mere beginnings of sharing with other professions, we are by no means clear as to what we share within social work as a whole as we emerge from a period of emphasis on development of special methods and special settings.

The frame of reference for this particular approach to our topic therefore includes several propositions.

Proposition 1. Every social worker in every setting has need to

[1] Ronald Lippitt, Jeanne Watson, and Bruce Westley, *The Dynamics of Planned Change* (New York: Harcourt, Brace & World, Inc., 1958).

understand the dynamics of group behavior. Various methods [2] of teaching this approach have been developing in social work education. The only agreement among educators is that there is no one pattern, method, or system and all are in a constant stage of revision.

The potential of this proposition as a diagnostic and treatment tool can only be suggested here. What is the nature of the child's social hunger? How is he accepted by his peers? Is he chosen on teams? Is he always the last to be chosen? If he has begun to feel better about himself through work with him and his family, what about the group into which he must fit? Have the teacher and the classroom group changed their ideas of him? Can they be helped as a group to recognize and accept the change? Lippitt reports on research which clearly indicates that indeed much work with an individual youngster regarding his own behavior is futile unless it is also accompanied by some work with the classroom group into which he must fit.[3]

Proposition 2. Every social worker in every setting has need for skill in facilitating the helping process in and through the group. A helping process can and does frequently occur among the members within a group whether or not the group is designed for this purpose or whether or not there is professional intervention to facilitate the helping process. Facilitation of this helping process can be a legitimate target of professional intervention at a number of levels, not only at the treatment group level, as a worker carries his total professional responsibility. A social worker, as a professional worker, makes a contract with society to behave in a responsible way, and to make use of his knowledge about the psychosocial needs of individuals, in any situation in which he may find himself in connection with his duties.

The widening scope of hospital social work delineated by Bartlett might well be applied to a number of settings currently in the throes of responding to many more demands for professional service than for casework service alone. As Bartlett comments:

[2] Grace Longwell Coyle and Margaret E. Hartford, *Social Process in the Community and the Group* (New York: Council on Social Work Education, 1958).

[3] Ronald Lippitt, remarks at meeting of Group Work Section, National Association of Social Workers, Detroit, 1959.

It is evident, however, that the casework frame of reference alone does not permit social workers to meet the expanding needs and demands of medicine, the hospital, and the community. Casework has been pushed beyond its capacity. . . . hospital social workers should regard themselves not merely as caseworkers but as social workers with skill in casework; they should have been trained in a broadly based curriculum that gives them a grasp of social work as a whole.[4]

For some time it has seemed to be evident that some of the confusion and occasionally heated hostility regarding the concept of generic social work has stemmed from a widespread tendency, as Bartlett comments, for caseworkers to equate casework with social work.

Papers by Rabinow [5] and Sherman [6] use phrases such as "use of casework concepts in parent group education," utilizing casework method and skill in group counseling, and "casework oriented group treatment." Thus the tendency to remain within the shell of casework services to individuals is less and less possible for social workers in many settings.

It would appear that in school settings for the role of the worker in engaging in services other than one-to-one casework has been expanding. Knowledge about group behavior and skill in use of self in a group situation are needed for responsible participation in a staff or board committee, in a community committee or group. Such knowledge and skill, of course, are obviously needed as specific assignments for staff service to such boards and committees are carried out.

Proposition 3. Demand for development of group services has far exceeded the supply. New curriculum designs in the schools of social work, and a growing amount of in-service training offered to those who customarily work with individuals, so that they may be

[4] Harriett M. Bartlett, "The Widening Scope of Hospital Social Work," *Social Casework,* XLIV (1963), 9–10.

[5] Mildred Rabinow, "The Use of Casework Concepts in Parent Group Education," in *Casework Papers, 1961* (New York: Family Service Association of America, 1961), pp. 131–42.

[6] Sanford N. Sherman, "Utilization of Casework Method and Skill in Group Counseling," in *Casework Papers, 1958* (New York: Family Service Association of America, 1958), pp. 46–60; and "Goals and Techniques of Casework-oriented Group Treatment," in *Casework Papers, 1955* (New York: Family Service Association of America, 1955), pp. 123–36.

educated toward a group-oriented philosophy, will begin to close the gap between our desire for what *should be* and our knowledge of *what is.*

At the 1963 meeting of the Conference on Social Work Education Dr. Mary Burns and Dr. Paul Glasser [7] presented the University of Michigan's preliminary formulation for teaching an approach to behavior and the helping process in social work which attempts to integrate theories of individual and group behavior. Provocative, stimulating, and upsetting though it may be for many a worker to picture himself as part of a thing called a "dyad" in a casework situation, the formulation appears to point the way toward future synthesizing, which we need desperately and which may develop rapidly once a firm beginning is made.

In the writings of Frey,[8] Falck,[9] Klein,[10] Konopka,[11] Glasser [12] and others we have a growing body of material helpful to workers and agencies as they move in the direction of developing group services.

Proposition 4. Questions of method and/or setting, questions regarding generic versus specialized practice, and questions related to practitioner and consultant roles beset both that set of theories and practice known as school social work and that set of theories and practice known as social group work. At the present time there is no definitive agreement regarding either among those workers most closely identified with both. Formal statements on practice have been formulated and accepted by both national professional groups. Questions of suitable educational requirements, questions of working directly with clients or on behalf of clients and similar questions are being dealt with both creatively and defensively.

[7] Mary Burns and Paul H. Glasser, presentation heard by the author, National Council on Social Work Education, January, 1963.

[8] Louise A. Frey, "Support and the Group: a Generic Treatment Form," *Social Work Journal,* VII, No. 4 (1962), 35–42.

[9] Hans S. Falck, "The Use of Groups in the Practice of Social Work," *Social Casework,* XLIV (1963), 63–67.

[10] Alan F. Klein, "Exploring Family Group Counselling," *Social Work,* VIII, No. 1 (1963), 23–29.

[11] Gisela Konopka, *Social Group Work: a Helping Process* (Englewood Cliffs, N.J.: Prentice-Hall, Inc., 1963).

[12] Paul H. Glasser, "Social Role, Personality, and Group Work Practice," in *Social Work Practice, 1962* (New York: Columbia University Press, 1962), pp. 60–74.

In 1961 William Schwartz charted a course for all of social work in focusing on "the need to combine the learnings of workers from the various fields and settings into a functional scheme that can be taught and practiced under the name of 'social work.' " [13]

Ruth Smalley, in her discussion of Schwartz's thesis, both supports his concept and sounds a warning:

> The general tenor of this proposition [development of social work theory] seems to me to have much to recommend it, and, to some extent it is already in process of realization. However, just as in stressing generic characteristics of social work methods whatever the field of practice, we have continued to emphasize the way a given field of practice (medical, public assistance and the like) *affects* method and introduces a specificity which must be taken into account and learned by the social work practitioner, so it is important to remember that differences in working with a single individual and working with a group also affect, and perhaps with even more complexity, the nature of the helping process itself.[14]

Thus on the one hand we may subscribe to Schwartz's challenge to move toward the development of social work theory, while at the same time heeding Dr. Smalley's reminder that we are far from such a goal.

It is assumed, therefore, in light of the foregoing propositions that the school as a group setting is not unique, special, or different but that it does offer distinct and obvious potentials for social workers in school settings to join forces with workers from other settings toward building a basic theory of social work as a helping process and toward understanding and using to the fullest the widening scope of social work practice in all settings. It would be considered axiomatic by any self-respecting school social worker that competent functioning has always included dealing with various group phenomena. We are addressing ourselves to current needs and current potentials of help to the worker to meet such needs.

Having delineated a frame of reference as that of the practice of

[13] William Schwartz, "The Social Worker in the Group," in *The Social Welfare Forum, 1961* (New York: Columbia University Press, 1961), p. 148.

[14] Discussion by Ruth Smalley, in *ibid.*, pp. 30–34.

social work in the schools, it is now possible to consider several facets of the functioning of the social worker in the school setting with reference to the need for understanding of the behavior of the individual in the group and group behavior in its broader sense, and for skill in facilitating the helping process in and through the group situation:

1. *Functioning as an observer.*—The school social worker has a rich potential for observing behavior of children in the real life setting of the here and now as youngsters take part in the routine life of the school. As we have seen, a fire-setter in a schoolroom raises questions not only about his individual need to set a fire, but also regarding his status in the classroom or peer group. Is he seeking acceptance and a higher rung on the status ladder among his peers? What is known about his natural peer group life? Is he part of a small chumship group of youngsters? Is he ever chosen spontaneously by his classmates? If so, for what is he chosen and for what is he rejected? Does he appropriately, for his age level, seek approval of peers in contrast to adult approval? Is he able to accept approval and recognition from peers? Is he able to share the adult figure, the supplies, the equipment? As he moves into preadolescence and adolescence is he able appropriately to identify with peers and to show rebellion toward adults? Is there a difference in his behavior in a formal group structure and in an informal group structure?

Either by direct observation, planned or casual, or through conferences with others who work with students, the social worker in the school can secure much valuable information related to the dynamics of an individual's participation in the group life of the school—provided the social worker knows the questions to ask, what to notice, and how to weave the results of both into helpful diagnostic deductions.

The planned design of short-term, small-group experience with a specific goal of diagnostic observation offers potential for valuable future development in the hands of workers equipped to handle such an approach. Consider the diagnostic clues for the worker in a small group of first- and second-grade boys in a group

considerably less structured than the classroom but by no means permissive:

Peter (a very infantile, overly dependent boy) one day stood pouting and then complained to the worker that there wasn't a scooter for him. The worker wondered aloud what anyone thought Peter could do about wanting a turn on the scooter. One sage member said, "You gotta say please," while another simply said, "If you wonna ride, say 'gimme that or I'll get you.' " The worker agreed that Peter himself needed to speak up, as the fellows said. He was soon careening about with great pleasure, as much due to pride at having worked it out himself with a peer as to the scooter itself.

2. *Functioning as a short-term dealer with groups.*—The social worker in the school setting traditionally has had this role. The worker must find the current fad of family treatment somewhat amusing. Sitting down with the whole family, visiting the home because of a crisis, working with various members of the same family throughout a school system indicate only in part the potentials for involvement with families on a group basis. School social workers can add to their skills, and to the services they give their clients, as can workers in any setting that is undertaking work with family groups, through an application of some of the basic concepts regarding groups. Grace Coyle points out the relevancy of group concepts to work with the family as a group:

One of the traps . . . personification of the group and then the application to it of the familiar and comforting concepts that have so successfully illuminated our understanding of the individual. . . . A group is a system produced by personalities in interaction with each other and with the group's surrounding society.[15]

She goes on to discuss the other easy trap of similar analogy attempts in relation to some of the theory from the social sciences.

A worker met over a period of several months with a gang-type group of junior high school girls who were referred to her because of their antisocial, acting-out type of behavior and because they were clearly recognized as a group within the school. She proceeded

[15] Grace L. Coyle, "Concepts Relevant to Helping the Family as a Group," *Social Casework*, XLIII (1962), 354.

to meet with the total group. The worker and the school lived through a period during which the girls transferred most of their testing to the group sessions, moving on then to direct work on their difficulties. The worker felt that all were reached much more quickly than if she had seen them individually and that the gains were solidified through the support the individuals gave to each other.

Without formal training in relation to group behavior, the worker emerged from this experimental approach firmly convinced of its value and equally firmly convinced of her need to increase her skill in facilitating the helping process in and through the group.

3. *Functioning as a consultant.*—The school social worker may function in the role of interpreter of behavior related to group phenomena through consultation. Many teachers are as well, or better, educated about group phenomena as many social workers. Familiarity with sociograms, participation in application of group dynamics theory, ease in seeing subgroups, knowledge of leadership patterns and growth of *esprit de corps* in a classroom group characterize many a sensitive teacher today.

Social workers have no monopoly on theory and skill in relation to group phenomena. Indeed, social workers have considerable catching up to do at spots. Nevertheless, it seems obvious that the school social worker has many opportunities to give consultation concerning group behavior, possibly particularly through helping in relation to self-awareness on the part of the interpretee, whether principal, teacher, coach, parent, or the boss of the cafeteria line. Obviously, the consultation will vary tremendously, depending on the individuals concerned. It may call only for understanding the distress of the principal when he accidentally hears that a junior high school boy feelingly said he'd "like to pull the principal's mustache out hair by hair," only to be seconded by another boy that would "like to take him and let red ants eat at his face."

Understanding on the part of the social worker of the outright terror sometimes felt by school personnel and parents in the face of group behavior of teen-agers, for instance, can provide an objective channel for ventilation of feelings on the part of the adults

and thence a chance to assimilate some new ideas regarding such behavior.

Much of the warfare between adults and adolescents needs to be understood on more than an individual psychology basis. Theories of transference and countertransference, of course, are easily applied. But the obvious support which individuals receive from their peer group, as well as the fact that adolescents soon learn how as a group they can frighten many adults, means that thorough knowledge of an adolescent's peer-group associations must accompany any attempt on the part of the individual social worker to understand the adolescent, and then attempt to help others to understand and work with or even live with the teen-ager, whether it be school personnel, social agency staff, or parents.

The social worker, if he has knowledge, skill, and experience in work with groups may well play a unique role as a consultant on group situations. This role is not a new one in social work, of course, but it is perhaps a comparatively recent concept that it is an appropriate one for a person skilled and experienced in work with groups. Indeed, increasingly the professional functioning of trained social group workers in the Girl Scouts, YWCA, settlements, and a host of settings where the professional works in relation to, or on behalf of, groups, but not in direct professional service to primary groups, is being considered a consultant role.

It is as a consultant that the social worker needs to have particular security in his knowledge and skill in order to set adequate limits on himself and on the expectations of others of his role. He could easily be drawn off into areas of group life which he and others might find interesting for him to speculate and theorize on. However, it would seem that consultation should be limited to the basic goals of the social work service in the school.

Very specifically, the use of knowledge and skills related to group phenomena on the part of the social worker in the school should be directed toward a specific goal of helping those individuals and groups who are evidencing difficulty in making use of the opportunity to be educated. It would not seem to be any more appropriate for the social worker to become involved with directly offering informal educational, recreational, or character-building group

activities than for any other member of the school staff. It would be hoped that as schools move toward development of group approaches as an integral part of social work services in the schools the social workers need not be concerned with directly offering group services with the broad, global, or diffuse types of goals. Just as the so-called "group-serving" agencies are struggling to divest themselves of the global goal of character building through group experience, it would seem to be clear that those who offer social services in the schools can well avoid such group approaches. Rather, the school social worker may well act as consultant on a thorough and complete evaluation of group activities, especially with the objective of raising questions about goals of these activities, measuring achievement of such goals, and supporting movement toward less blind acceptance of the theory that because the goals are global and noble the results must be large and uplifting.

Consultation may well take other forms also. In one junior high school irritation, disgust, and classic ill-feeling on the part of the staff mounted toward a small group of boys who were needling the entire faculty and all others whom they could annoy. In discussing the situation with the social worker, the principal was struck by the worker's comment that the faculty's feelings as a group seemed to be both disturbed and mobilized. At the principal's suggestion, the social worker agreed to meet with the entire faculty for the specific purpose of enabling ventilation of feelings as well as providing an opportunity to suggest next steps to be taken by the faculty as a whole. The social worker, who had had training and experience with groups, served as discussion leader in the meeting. Initially, the teachers' feelings of "just plain having had it from those kids" were expressed as expected. Then came some isolated comments on more positive aspects of some of the boys' behavior. Next, some of the teachers showed real knowledge of and concern about, the home life of some of the boys. When agreement from the social worker as to the boys' need for kind but firm limits gave the faculty some sense that the situation was not a battle for the boys and against the faculty, individual teachers offered specific suggestions. The art teacher volunteered to provide some special opportunity for one of the boys who had shown an interest in

art. It was agreed that supporting the boys in their efforts to do good work in any way possible would be followed by all, but that they would not let the boys get away with anything, such as wandering the halls. It was also suggested that the families should be more involved in their boys' school situation, with the point being made that the families needed to know how concerned the school was and what efforts the staff were making to help the boys.

Handling the feelings of the faculty as a group was done directly by the social worker. This is offered as an example of the role of consultant on a specific situation and as discussion leader in the specific process of consultation, rather than as a projected role of the worker to meet regularly with the faculty as a group.

4. *Functioning as group educator.*—The social worker in the school setting often functions in the role of group educator, both short-term and long-term, formal and informal. It is obvious that the more the social worker is familiar with and competent in facilitating the helping process in and through the group the more effective such group education can be. Speaking at PTA meetings, conducting short-term orientation series for parents, such as pre-kindergarten enrollment meetings, encouraging parents of junior high or senior high school students to attend meetings—these are some of the ways in which workers function.

It is with deliberate intent that this function has been labeled an "educational" one. However, it is to be hoped that this does not mean that the concept of the function need be limited to the role of giving out information. Much of family life education and adult education seems to have been of this bias in the past. Instead we can with imagination quickly envision groups which are definitely educational in purpose, but in which learning is conceived of as taking place through emotional involvement not just through intellectual exposure. In other words, here as in all our group potentials, it is the skill and sensitivity with which the worker enables the group to handle feelings about facts as well as to discuss facts which makes the service appropriately social work.

We may see some guidelines for future development:

1. Growth of theory and practice as related to group phenomena in a school setting makes it mandatory no longer to consider

whether the social workers need to have knowledge and skill related to group phenomena but rather how they may acquire it and deepen it.

2. Theory and practice, with accompanying clarity as to education and training requirements, for the practice of social work in the schools, including skill in facilitating the helping process in and through the group, require much greater conceptualization and refinement.

We might theorize *ad infinitum* about potentials of group experience. We may jump on the bandwagon of enthusiasm for group, group, group, any kind of group. We could be so horrified by the theorizing and the careening bandwagons that we remain frozen and immobile, or at least rigidly defend the *status quo*.

We must have faith in disciplined study, planned experimentation, and trust in the true artistry of creative experience to help us find answers in an orderly way.

Family Unit Treatment of Character-disordered Youngsters

by DAVID HALLOWITZ

THE DIFFICULTY, ENORMOUS INVESTMENT of professional time, and minimal effectiveness of treating character disorders, including character-disordered adolescents and their parents, through the traditional one-to-one relationship has long been acknowledged. Discussing psychopathic behavior in adolescents, Ackerman states that

> psychopathic conduct in adolescents cannot be treated effectively if we try exclusively to treat the adolescent as a separate individual. . . . I have been taught that psychopathic personality is an untreatable condition. And so it is if one undertakes to treat a psychopathic adolescent in isolation from his family and community.[1]

With reference to delinquent adolescents, Aarons observes that "the treatment of delinquency is a difficult and unrewarding task. Few psychiatrists are willing to devote the time and effort required for the intensive and prolonged treatment that may be necessary." [2]

In discussing adolescents with character disorders, Gordon states:

> Character disorders are a group about which there is almost unanimous agreement regarding our general lack of success in modifying behavior with therapeutic techniques which work so well with neurotic patients. The often-quoted ratio "Two thirds improve with treatment" refers primarily to neurotics.[3]

. . . .

[1] Nathan W. Ackerman, M.D., *The Psychodynamics of Family Life* (New York: Basic Books, Inc., 1958), p. 235.

[2] Z. Alexander Aarons, M.D., "Some Problems of Delinquency and Their Treatment by a Casework Agency," *Social Casework*, XL (1959), 254.

[3] Sol Gordon, "A Psychotherapeutic Approach to Adolescents with Character Disorders," *American Journal of Orthopsychiatry*, XXX (1960), 757.

The enormous investment of time and energy which these cases require suggests to us that it is not sound professional practice for any treatment load to include more than a few of the serious character disorders.[4]

Yet, the heaviest demand for service in family agencies and child guidance clinics is in cases of this kind. Discussing the preponderance of character problems in family agencies, Pollak and others state:

Persons suffering from the classic symptom neuroses . . . have all but disappeared from agency caseloads. . . . At the present time, the most challenging task confronting social caseworkers is learning how to deal therapeutically with persons with character disturbances.[5]

This trend of the neuroses giving ground to the character disturbance was noted in 1945 by Fenichel:

A fundamental change in the clinical picture of the neuroses during the last decades is that instead of clear-cut neurotics, more and more persons with less defined disorders are seen, sometimes less troublesome for the patients themselves than for their environment.[6]

Keenly aware, out of our own clinical experience, of the foregoing problem and challenge, we started working six years ago with character-disordered youngsters and their parents as a family unit, actively involving the family court, the school, and other community resources as an integral part of the treatment program. Our hypothesis was that this would prove to be at least as effective as individual psychotherapy, with substantially less investment of professional time. Our preliminary paper, written in 1961, dealt fully with the philosophy, process, and dynamics.[7]

The purpose of the present communication is to present the findings of a study of thirty-eight cases in which this treatment process was used, delineating the factors that have made for a

[4] *Ibid.*, p. 765.

[5] Otto Pollak, Hazel M. Young, and Helen Leach, "Differential Diagnosis and Treatment of Character Disturbances," *Social Casework*, XLI (1960), 512.

[6] Otto Fenichel, M.D., *The Psychoanalytic Theory of Neurosis* (New York: W. W. Norton & Company, Inc., 1945), pp. 463–64.

[7] Albert V. Cutter and David Hallowitz, "Diagnosis and Treatment of the Family Unit with Respect to the Character-disordered Youngster," *Journal of the American Academy of Child Psychiatry*, I (1962), 605–17.

favorable or unfavorable outcome. The results were also compared with those of a group of similar cases in which traditional individual psychotherapy was used for the child and parents. Before presenting the methodology and findings of this study, it is first necessary to describe briefly our concept of the "character-disordered youngster" from a diagnostic standpoint and the family unit treatment process used. This will not be a recapitulation but will contain fresh thinking and additional important concepts derived from the more recent experience of the past two years.

The youngsters, ranging in age from eleven to sixteen, in the thirty-eight cases studied, were severely maladjusted in the home, school, and community. At the point of application to the clinic, they were maladjusted in one or more of the following ways: almost beyond the control of the parents; about to be suspended or expelled from school for the last time; apprehended by the police without court action; under the jurisdiction of the family court because of overt delinquent acts, or being ungovernable. The antisocial behavioral symptoms consisted of stealing, severe aggression, defiance, destructiveness, vandalism, inattention to responsibilities at home and school, running away, and sexual aberrations. In several youngsters, this behavior was of the neurotic acting-out kind. Specific neurotic symptoms—enuresis, soiling, sleep disturbances, and psychosomatic complaints—were found in thirteen youngsters. In six, prepsychotic and psychotic trends were also in evidence.

In all thirty-eight cases, even those with mixed symptomatology, the diagnosis was that of character disturbance. Thirty-four of the youngsters were evaluated through psychiatric examination and psychological testing. Various diagnostic terms used by the examiners were: "character disorder"; "personality trait disturbance"; "passive-aggressive personality"; "conduct disorder, severe"; "sociopath"; "psychopathic personality"; and "adjustment reaction of adolescence, antisocial behavior." The author relied, principally, on the descriptive diagnostic statements of the examiners. Invariably, even though neurotic and psychotic symptoms and trends were noted, neurosis, prepsychosis, and psychosis were ruled out. Most prominently described in these diagnostic statements

were such factors as: emotional immaturity, emotional deprivation, generalized angriness, overwhelming hostile and aggressive impulses, weak ego and superego, impulsivity, and impaired capacity for relationship.

The difficulty of precise diagnosis is understandable. Although psychosexual development had been seriously disrupted, the emotional difficulties were still in a fluid state. In some, normal processes of psychosexual development could be fully restored; in others, only partially so; and in a few, the condition was already a full-blown character disorder or psychopathic personality. As Ackerman states with respect to psychopathic conduct in adolescents: "Such behavior is observed clinically in all degrees of intensity. Some such conditions are mild, others malignant." [8] To convey the connotation of fluidity and lack of crystallization of a youngster's character disturbance, we used the term "character-disordered."

The operational diagnostic framework we conceptualized consisted of the following elements: (1) generalized emotional immaturity; (2) marked narcissism and egocentricity; (3) poor ego control; (4) little or no superego development; (5) impaired capacity for relationship, characterized by flatness of affect, distrust, withholding and withdrawal. This was similar to Ackerman's formulation with respect to the adolescent who presented psychopathic behavior:

> impulsiveness, antisocial conduct, defective control and judgment, lack of foresight, shallow emotionality, egocentricity, magic omnipotent thinking, power striving, grandiosity, inability to empathize with others, a failure to respect the rights of others, a lack of genuine guilt, failure to learn from experience, and deviant sexual behavior.[9]

Even though our operational diagnostic framework was admittedly descriptive and simplified, the psychodynamic underpinnings were readily discernible and almost self-evident. In the thirty-eight cases studied, the youngsters suffered severe emotional deprivation and felt unloved and rejected by one or both parents. In several cases, this was brought about by a radical breakup of the family, resulting in foster home and institutional placements. The disas-

[8] Ackerman, *op. cit.*, p. 236. [9] *Ibid.*

trous effects of this upon the developing personality are described by Eisenberg.[10] In the majority of cases, however, emotional deprivation and the child's feeling of rejection were generated with considerable power and intensity in the vicious cycle of the conflicts and breakdowns in the parent-child relationships of intact families.[11] Whatever the cause, the major psychosocial dynamics seemed to be: deficiency in emotional nurture; disruption of the normal identification processes; lack of or faulty resolution of the oedipal conflict; and failure to pass completely from lower to higher stages of psychosexual development. As Fenichel states, "it is not a question of dealing with a hitherto uniform personality but, rather, with one that is patently torn or malformed." [12]

Many of the parents were in basic marital conflict and also appeared to have character problems which impaired their ability to provide the growth-promoting relationships for the child.[13] In only a few cases was it suspected that the parents were acting out through their children antisocial tendencies of their own.[14] Not to be overlooked or minimized were the powerful social forces outside the family which fed into the development of character disturbances.[15]

The basic pattern of interviews was that of the therapist meeting with the parents and youngster together, varied by individual interviews with the youngster and parents. Siblings and relatives living in the home were included in the family sessions as needed. Interviews usually were held weekly in the beginning phase, then scheduled at less frequent intervals, depending upon the extent of progress and the ability of the family to maintain or carry it forward independently. At points of crisis, a return to weekly interviews occurred.

[10] Leon Eisenberg, "Sins of the Fathers: Urban Decay and Social Pathology," *American Journal of Orthopsychiatry,* XXXII (1962), 5–17.

[11] David Hallowitz and Burton Stulberg, M.D., "The Vicious Cycle in Parent-Child Relationship Breakdown," *Social Casework,* XL (1959), 268–75.

[12] Fenichel, *op. cit.,* p. 464.

[13] Eisenberg, *op. cit.;* Beatrice S. Reiner and Irving Kaufman, *Character Disorders in Parents of Delinquents* (New York: Family Service Association of America, 1959).

[14] Stanislaus A. Szurek, "Notes on the Genesis of Psychopathic Personality Trends," *Psychiatry,* V (1942), 1–6.

[15] Marshall B. Clinard, *The Sociology of Deviant Behavior* (New York: Rinehart, 1957); Eisenberg, *op. cit.;* Pollak, *op. cit.*

The therapist helped them talk about the current problems of concern to them; the circumstances, events, and conditions that gave rise to these problems; vital medical and developmental history; and the weaknesses and breakdowns in the parent-child and parent-parent relationships.[16] Long-suppressed and withheld feelings of anger, frustration, failure, and hopelessness on the part of the parents toward the youngster and each other, and the youngster's comparable feelings toward the parents, came into the open. If these powerful feelings had been expressed at home, it was in the form of violent, destructive quarrels. Such quarrels often characterized the early interviews, but the therapist helped the family to gain control over their emotions; to see the destructive nature of their constantly fighting with each other and how this aggravated the youngster's rebelliousness and antisocial behavior; and to become aware of the factors in the past life of the family which caused the relationship breakdowns and the youngster's behavior patterns. Some children were not able, in the beginning, to express their feelings verbally in the family interviews but did so nonverbally, through crying, angry looks, bitter smiles, doubting and scoffing sounds, and the like.

Believing it to be important, but not always necessary, that the youngster make known his feelings as fully as possible, the therapist would meet individually with him, either as part of the same hour or in one or more separately scheduled interviews. The therapist actively tried to reach the youngster and enable him to bring forth his feelings. When the resistance, based on a pattern of withholding feelings and being distrustful of adults was strong—and it usually was with these youngsters—the therapist talked interpretively to him about how he must really feel toward his parents and siblings.

An extreme example of this occurred with a sixteen-year-old boy who refused to come for interviews at the outset and was abusive, destructive, and violent at home. The therapist went to the home and spoke to him through his closed bedroom door. Between the

[16] David Hallowitz and Albert V. Cutter, M.D., "The Family-Unit Approach in Therapy: Uses, Process, and Dynamics," in *Casework Papers, 1961* (New York: Family Service Association of America, 1961), pp. 44–57.

youngster's abusive epithets, the therapist told him, in effect: "You're carrying on this way with me and your parents because you feel they don't want you. You thought you could live with your grandparents but they didn't want you either. You feel completely alone and unwanted. That's an awful feeling. I've met with your parents. They are very angry with you and wanted to be rid of you only because they couldn't take it any longer. Yet, they do want you with them, if you will only meet them halfway." The boy listened. Shortly afterward, he came with his parents for the first family unit session.

A youngster who could not at first participate verbally in the family unit sessions became ready to do so when he saw that the therapist understood him and really cared about him. After he revealed his feelings privately to the therapist, the latter discussed with him the importance of his telling the parents about these feelings. Invariably, the youngster agreed either to do this himself in the next family interview, or to do it with the therapist.

What were these all-important feelings which sooner or later the youngster and the parents expressed to each other? A youngster might have felt that his parents did not love him; that they loved the other children or a particular sibling more than him; that "they put me away and told me they didn't care if they never saw me again"; that they constantly criticized and found fault with him, comparing him to the better adjusted siblings or peers; that they were constantly angry with him; that they were too strict and unreasonable; that they treated him "like a baby"; that they had no time for him, particularly the father, who had not done anything with him for years; that his mother and father were always fighting with each other—perhaps with physical violence—which frightened and upset him; that one or both parents drank too much; and so on. The parents might have felt that the youngster did not care about and rejected them; that he cared only about himself, as evidenced by his evading responsibilities in the home; that he was hostile and mean to them and others in the family; that he was wasting his good intelligence and abilities by failing and getting into trouble at school; that they hated and could not stand him at

times because he behaved and treated them so badly; but that, deep down, they loved him and wanted to love him if he would only let them.

Opening up the lines of constructive communication between the parents and the child with respect to these feelings was the foundation of the family therapy. But this was not enough. One could not expect character-disordered youngsters and parents who themselves had character disturbances independently to apply their new-found understandings toward changing their patterns of behavior and relationships. They needed concrete direction and guidance within a structure of controls. This was especially true of the youngster.

Although recurrently the underlying feelings in the relationships were expressed and discussed, the focus and emphasis of therapy shifted markedly to an action program; that is, the youngster and his parents made agreements and decisions to try new modes of behavior in the family and, for the youngster, in the community. The therapist held them to their agreements and, sometimes gently, sometimes sharply, took them to task if they failed to follow through. They did this with each other as well in the family sessions. Particularly with a youngster, the therapist pointed out in no uncertain terms what the consequences of his behavior would be. "Do you want to land in the hospital for mental observation?" the therapist said to one adolescent. "When you lose control," he continued, "and rip up the furniture, strike your mother and threaten to kill her, you are mentally ill at those moments and definitely need hospitalization. But you are not really mentally ill and you have shown that, when you really want to, you can control yourself. It would be most unfortunate if you push your parents to the point where they will have no choice but to hospitalize you. Is this what you want? Maybe you do. Some people have a need to punish themselves unmercifully." The therapist would talk similarly to the youngster about his stealing, running away, causing a disturbance in school, and so forth.

Because the use of external controls is an important dynamic of treatment, the therapist would often involve the school and the

family court.[17] If the youngster was unable to control himself, and was beyond the control of his parents, the therapist helped the parents take the step of filing an ungovernable-child petition with the court. He explained to the boy that this was not a punitive measure but a way to help him gain self-control. Usually, the judge's disposition was to place him on probation. With these youngsters and those referred originally by the court, there was then the benefit of a potentially vital source of external control. The therapist worked in coordinated fashion with the probation officer, explaining to the youngster why he was doing this. The therapist did the same with respect to the school. Some family interviews were held with the probation officer or school representative as full participants. When necessary, the therapist would also tell the boy that he requested weekly reports from the school so that he could better help him with his adjustment problems. At times, the therapist held telephone conversations with the probation officer, or school representative, in the presence of the youngster. At no time did the therapist find that a child regarded this as a betrayal of confidentiality or a lack of trust in him. The youngster realized intuitively that he needed these controls, and the active use of them by the therapist, to bolster his own weak ego and superego structure.

The therapist learned that it was important to develop an individualized relationship with the youngster, over and above that which was being built up in the family sessions. This was accomplished through a series of individual interviews. The family process, however, was never lost sight of, but pertinent aspects of it were woven into the individual interviews. Conversely, pertinent aspects of the individual interviews were woven back into the family sessions. The content of the individual interviews remained essentially the same as that of the family sessions. However, the youngster had greater freedom to express his feelings and his personality in the context of an individualized relationship. The therapist also had greater freedom to express himself to the youngster directly. Play sessions with the preadolescents, and with certain

[17] Irving Weisman and Jacob Chwast, "Control and Values in Social Work Treatment," *Social Casework*, XLI (1960), 451–56.

adolescents were also used, but the basic issues of social adjustment within the family and society were continually discussed with them.

Crises with the character-disordered youngster were anticipated and accepted as "par for the course." As Berman puts it, "this type of family may need to use his skills for a long period of time, and . . . many crises will arise." [18] In fact, the heightened anxiety created an opportunity to extend and deepen the treatment process. The therapist, therefore, did not give up hope if a youngster committed a delinquent act again. The therapist dealt dynamically with him and the family unit in terms of what it represented. One youngster wanted to find out if the parents and therapist would still like him despite his badness. Another could not withstand the pressure of the gang. Another could not resist the temptation to satisfy a narcissistic desire for the money and objects he stole from a store. Another had a feeling of hopelessness and despair when his girl rejected him. Another was so infuriated by a physical fight with his drunken father that he deliberately beat up a boy in the street.

Dynamic sessions were held with a sixteen-year-old adolescent and his parents in each of three separate crises, when the youngster was arraigned in court for vandalism and theft. Writing to him in the jail and visiting him in the hospital also meant a great deal to him. The therapist's objective and interpretive report to the court was a factor in the judge's deciding upon the continuation of probation. Working intensively with the youngster and the parents in these crises deepened the therapeutic relationship.

The therapist's role had several interrelated and changing dynamic aspects. He tried to help the family members gain a better understanding of themselves as individuals and of each other, through which improved family relationships might come about. The therapist and the clinic represented a source of control, and he brought into play other societal controls. The major treatment dynamic was that he served in a transference sense as the stable parent to all. His interest in, and his caring deeply for, the family

[18] Sidney Berman, M.D., "Antisocial Character Disorder: Its Etiology and Relationship to Delinquency," *American Journal of Orthopsychiatry*, XXIX (1959), 620.

as a whole was effectively conveyed. The therapist guarded against overidentifying with one or another family member. On specific issues, overidentification was unavoidable and even necessary because the therapist had to be a real person with real feelings and opinions. However, he balanced this out by identifying more or less equally with the other family members. This was not too difficult to do, because in every conflict situation there usually were "two sides to the story." As the individualized relationship with the youngster developed, the therapist also became the understanding adult friend with whom the youngster identified in terms of furthering his psychosexual development. It was hoped that identification processes on the part of the youngster with the parents would be liberated by the family unit treatment so that the relationship with the therapist would have only transitional significance. However, when parents remained limited in their capacities for relationship, the therapist planned to continue his relationship with the youngster for years to come.

Let us now turn to the findings in the study of the thirty-eight cases. The major focus was upon trying to ascertain the factors which made for a favorable or unfavorable outcome. A favorable outcome was defined as one in which the youngster and his family showed either symptomatic improvement or improvement on a deeper level. An unfavorable outcome was one in which there was no improvement symptomatically or in the basic character structure. The criteria for improvement were based on clinical observation and judgment. Results were determined, not only at the point of termination at the clinic, but also on the basis of follow-up from one to three years afterward. If a family reverted to its original predicament within this time span, and it could not be helped to regain the improvement previously made, it was counted as a case of unfavorable outcome. It is possible that a few of the cases of favorable outcome, not yet followed up for the full three years, will turn out to be unsuccessful. However, this is not likely to affect appreciably the results now being reported.

Of the twenty-three cases with a favorable outcome, six youngsters (25 percent) showed mainly symptomatic improvement in the sense that they gained in self-control and improved functioning

within the family and community. There was no significant progress in their basic personality structure and family relationships. In the remaining seventeen youngsters (75 percent), there was marked improvement, not only in external adjustment and functioning, but also in psychosexual development and maturation. That is to say, narcissism gave way to concern and consideration for the feelings of others; the youngster's capacity to form more mature relationships was enhanced; the parent-child relationships especially were improved; the youngster gained in self-esteem, self-confidence, and self-control; and he gained a larger measure of happiness and direction in life. The relationship between the parents, as well as the parent-child relationships, also improved so that the forces and potentialities within the family for normal growth and development of the child were liberated.

With respect to the unsuccessful cases, six youngsters were sent by the family court to a correctional institution or residential treatment center; and two to a child-care institution. The remaining seven families dropped out of the clinic.

Degree of antisocial behavior.—It must be borne in mind that all thirty-eight youngsters were at the extreme end segment of the spectrum, in terms of the range of antisocial behavior on the part of the total child population of the clinic. Forty-seven percent, for example, were under the jurisdiction of the family court. Examining the extent and intensity of antisocial behavior in specific areas—home, school, community—the author placed these youngsters on a rating scale: first degree, second degree, and third degree. For example, if the boy was intolerable at home, in school, and was arraigned in court for delinquency, he would be placed in the first degree of the rating scale; if his aberrant behavior was con-

TABLE 1

Degree of Antisocial Behavior	*Favorable Outcome*		*Unfavorable Outcome*	
	No.	*Percent*	*No.*	*Percent*
First degree	11	48	12	80
Second degree	7	30	2	13
Third degree	5	22	1	7
Total	23	100	15	100

fined only to the school, he would be placed in the third degree of the scale. Again, these were clinical judgments.

The degree of antisocial behavior was greater in the cases of unfavorable outcome: 80 percent were in the first degree. By contrast, 48 percent of the cases of favorable outcome were in the first degree.

Chronicity of the basic character disturbance.—The chronicity of the presenting problems of antisocial behavior was essentially the same for the cases of favorable outcome and those of unfavorable outcome. However, there was a significant difference in these two groupings with respect to symptoms of maladjustment prior to the onset of the antisocial behavior. These symptoms of maladjustment varied directly with the amount and degree of emotional deprivation.

TABLE 2

Chronicity of Character Disturbance	*Favorable Outcome*		*Unfavorable Outcome*	
	No.	*Percent*	*No.*	*Percent*
2–4 years	3	13	2	13
4–6 years	9	39	1	7
6–8 years	5	24	3	20
8–10 years	6	24	9	60
Total	23	100	15	100

The chronicity was greater in the cases of unfavorable outcome: 60 percent in the 8–10 year chronicity-grouping; contrasted with 24 percent in the cases of favorable outcome.

Marital relationship.—The marital relationship between the parents was evaluated on the basis of clinical observation and known history. It goes without saying that in all thirty-eight cases the ability of the parents to work together in behalf of the character-disordered youngster was deficient. However, this was a greater problem for those parents who were in marital conflict with each other. The marital conflict, invariably, was of long standing.

There was a greater incidence of marital discord in the cases of unfavorable outcome (33 percent) than in the cases of favorable outcome (9 percent).

TABLE 3

Marital Relationship	*Favorable Outcome*		*Unfavorable Outcome*	
	No.	*Percent*	*No.*	*Percent*
Good marital relationship	17	74	7	47
Poor marital relationship	2	9	5	33
Mother only: due to divorce	3	13	3	20
Mother only: due to death of father	1	4	0	0
Total	23	100	15	100

Additional psychopathology in the youngster.—In six out of the fifteen cases (40 percent) of unfavorable outcome, there was strong suspicion by the examining psychiatrists and psychologists of underlying psychotic trends, subordinate to the character problem but potentially dangerous from the standpoint of possible mental illness ultimately. This factor was not present in the cases of favorable outcome.

Skill of the therapist.—Although the author was the therapist in all thirty-eight cases, his skill developed with increasing experience. It is conceivable that perhaps some of the early cases which had an unfavorable outcome might have fared better if the therapist's experience and skill had been at their subsequent higher level.

Other possible variables studied included the following:

Age.—The median age for the total group of thirty-eight youngsters was fourteen years. There was no significant deviation from this in the cases of favorable and unfavorable outcome.

Sex.—There were only five girls (13 percent) among the thirty-eight youngsters. This was too small a number to compare with the boys. Three had a favorable outcome; two were unfavorable: not significant.

Chronicity of presenting symptoms of antisocial behavior.—The median for the thirty-eight cases was three years. There was no significant deviation in the cases of favorable and unfavorable outcome.

Parental psychopathology.—In fifteen out of the thirty-eight cases (39 percent), one or both parents were found clinically to have obvious character disturbances. These cases were proportion-

ately distributed between the cases of favorable and unfavorable outcome. These particular parents were not evaluated diagnostically through psychiatric evaluation and psychological testing. In regard to other psychopathological conditions in the parents, no history was reported and none was in evidence clinically.

Adopted youngsters.—There were three adopted youngsters in the cases of favorable outcome; four, in the cases of unfavorable outcome: not significant.

Economic and social position of the family.—Using such gross indicators as income, occupation, education, and geographical location, the distribution for the thirty-eight families was:

TABLE 4

	No.	*Percent*
Upper socioeconomic group	4	11
Middle socioeconomic group	4	11
Lower middle socioeconomic group	19	50
Lower socioeconomic group	11	28
Total	38	100

There was no significant difference between the cases of favorable and unfavorable outcome.

Ordinal position, intelligence, and duration of treatment.—These factors were found not to have any significance in the cases of favorable outcome as compared with those of unfavorable outcome.

The expenditure of professional time is an important issue in the treatment of character-disordered youngsters and their parents. Moreover, the efficient use of professional time is of general importance in the field of mental health in view of personnel shortages. The data of the thirty-eight cases is summarized below in terms of duration of treatment and number of professional hours invested. It must be remembered that frequency of appointments in the family unit process changes flexibly with progress and reverses, so that while it is possible to have a case in treatment for a long time the total number of interviews may still be relatively small. In regard to the tabulation of treatment hours, the relatively few

individual sessions were counted together with the family unit sessions.

TABLE 5

No. of Cases	*Duration of Treatment*	*Average No. Treatment Hours per Case*
8	1–3 months	5
7	3–6 months	5
5	6–9 months	10
6	9–12 months	27
6	1–1½ years	23
5	1½–2 years	17
1	3 years	33
		avg. per case 17
	Median treatment duration: 6–9 months	Median no. treatment hours per case: 20

A comparison group of thirty-eight cases (Group II), in which the youngsters and parents were treated separately by two therapists, was randomly selected. These youngsters had essentially the same basic character disturbances as the youngsters in the family unit study group (Group I). The incidence of antisocial behavior was less in Group II, compared with Group I. For example, six youngsters of Group II were under the jurisdiction of the family court compared with eighteen in Group I. The median age of Group II was twelve years, compared with fourteen years of Group I. With respect to all the other possible significant variables, the two groups were similar. The comparison focuses upon results and expenditure of professional time.

The results in Group II were derived by use of the same criteria used for Group I. The over-all comparative results were as follows:

TABLE 6

	Group I		*Group II*	
Results	*No.*	*Percent*	*No.*	*Percent*
Favorable outcome	23	61	15	39
Unfavorable outcome	15	39	23	61
Total	38	100	38	100

TABLE 7

Professional Time	*Group I*	*Group II*
Median treatment duration	6–9 months	1–1½ years
Average treatment hours	17 hours per case	79 hours per case
Median treatment hours	20 hours per case	68 hours per case

The treatment duration of cases in Group II was two times greater than in Group I. The investment of professional time was three to five times greater in Group II than in Group I. The difference between Group I and Group II can further be seen by the following: no case of Group I exceeded forty-three hours while eleven cases in Group II (29 percent) ranged from 100 to 189 hours.

The great difficulty of effectively treating character-disordered youngsters and their parents by traditional methods has been amply covered in the literature. The examination of the thirty-eight cases in which individual treatment was rendered yielded further documentary evidence.

The author attempted to define the diagnostic term "character-disordered youngster" and the underlying psychodynamics. This too was found to be in consonance with the writings of others on the subject.

This study suggests that the family unit treatment process is a valid one for character-disordered youngsters and their parents. A favorable outcome of 61 percent, however, still leaves much to be desired in terms of treatment effectiveness. Perhaps treatment effectiveness can become enhanced by the findings of this study and by the further development of skills.

One can become more enthusiastic about the family unit treatment process for character-disordered youngsters when this is applied to the mild and moderate disturbances. In cases of this kind, the character disturbances are not too advanced in their development and the underlying causative factors, not too severe. Conversely, there is greater emotional health and ego strength in the youngster and family. Our clinic has not had a sufficient amount of experience as yet in the use of the family unit treatment process with the mild and moderate character disorders. In fifteen cases

recently terminated, a favorable outcome in fourteen (93 percent) seems to be assured. The average number of treatment hours per case was ten. It is fairly safe to say that a comprehensive study of a larger number of such cases, after termination and with about a three-year-follow-up, will show a much higher percentage of successful outcome than can now be reported for the severely character-disordered youngsters and their families.

The Social Worker in a Suicide Prevention Center

by S. M. HEILIG and DAVID J. KLUGMAN

DR. KARL A. MENNINGER, in the Foreword to *Clues to Suicide,* states:

> Once every minute, or even more often, someone in the United States either kills himself or tries to kill himself with conscious intent. Sixty or seventy times every day these attempts succeed. In many instances, they could have been prevented by some of the rest of us.[1]

The U.S. Public Health Service reports that suicide is among the first ten causes of adult deaths in the United States. In certain age groups (fifteen to twenty-five) and in certain occupational groups (college students, peacetime soldiers), it is the third cause of death. It claims victims without discrimination from all social classes and from all socioeconomic levels. Further, a suicide often affects the mental health of many survivors and, thus, the community itself. The magnitude and seriousness of this public health problem led to the foundation, in 1958, of the Suicide Prevention Center (SPC) in Los Angeles—dedicated to saving lives and to furthering basic understanding about the phenomenon of suicide.

The SPC was established within the purview of a five-year (1958–63) U.S. Public Health Service (National Institute of Mental Health) project grant. In 1962 a seven-year project grant from the U.S. Public Health Service was awarded, and this is the present source of support. The grants have been administered through the University of Southern California.

[1] E. S. Shneidman and N. L. Faberow, eds., *Clues to Suicide* (New York: McGraw-Hill Book Co., 1957), p. vii.

The project is directed by Edwin S. Shneidman and Norman L. Farberow, Co-directors, and Robert E. Litman, M.D., Psychiatrist-Director. The staff consists of two half-time psychiatrists, two psychologists, five psychiatric social workers, one biometrician, one research associate, and consultants in psychiatric nursing and sociology.

The activities of the SPC are directed toward five primary goals:

1. The first and foremost goal is to save lives. Specifically, this means that the SPC is set up to make psychiatric, psychological, and social work evaluations and then to treat or make referrals for persons who are thought to be potentially suicidal. The goal is, not only to save a life at a particular time, but also and equally important, to institute those therapeutic procedures which will reduce the possibility of an individual's attempting or committing suicide at some time in the future.

2. The second goal is to demonstrate that such a center can play a vital role in the health and welfare activities of a large metropolitan community and can establish itself so that the community will eventually wish to maintain and support it; further, that such a center may serve as a pilot project or model for other communities to adapt to their own specific needs.

3. The SPC's purpose is to be a training and educational center in suicide prevention for professional and interested lay personnel, selected from various disciplines and from different geographical areas.

4. By virtue of its very existence, the SPC endeavors to reduce and modify long-standing taboos concerning the study of suicide.

5. It is the SPC's aim to collect and collate heretofore unavailable data regarding suicidal phenomena and to employ this scientific information to develop and test hypotheses concerning suicide. It is hoped that this procedure will lead to more accurate prediction and, ultimately, to lower suicide rates.

The SPC is organized into three closely interrelated sections: (1) the clinical section; (2) training and education; and (3) research and theory. The clinical section functions as an around-the-clock community emergency psychiatric clinic, using the skills of psychiatrists, psychologists, and social workers to study, evaluate,

treat, and, often, to refer to community resources persons who are suicidal. Service here is foremost, and this means being easily and readily available to suicidal persons. There are no eligibility requirements, such as age, sex, race, religion, or income, and no geographical restrictions, no fees, and no waiting list. In short, there is nothing to prevent a staff member from seeing immediately anyone who is suicidal and who needs help, at any hour of day or night.

The training and educational section plans, coordinates, and carries on a number of programs. A formal training program has been established for university students in psychiatry, psychology, psychiatric social work, and public health psychiatric nursing. Professional graduates and practitioners may receive postdoctoral appointments for periods of one year or less and obtain clinical training and supervision from members of the SPC staff. Arrangements may be made to consult with and train responsible persons who represent other communities that wish to open suicide prevention agencies. Lastly, workshops, lectures, and public presentations to both professional and lay groups, locally and nationally, are held.

The research and theory section attempts to investigate why individuals take their lives, so that suicidal behavior can be more effectively prevented in the future. The data for the numerous ongoing studies within the section consist of suicide notes, case histories, psychological test data, social work data, information from the coroner's office, and sociological data from the community. In addition to its ongoing research functions, there was established in 1962, within the structure of the SPC, the Center for the Scientific Study of Suicide (CSSS). The CSSS is the theoretical research arm of the SPC. Each year it will invite a few outstanding scholars to the CSSS to study as Fellows and to apply their particular wisdom to the manifold problems of suicide prevention.

The goals of the SPC encompass integration with other mental health agencies in the community. With this in mind, liaison has been established with the Los Angeles city and county health departments, the Los Angeles city and county police departments,

the Welfare Planning Council, and the California State Department of Mental Hygiene.

Our unique relationship with the Los Angeles County Coroner's Office—and especially with the Chief Medical Examiner-Coroner, Theodore J. Curphey, M.D.—merits special mention. SPC staff members have been deputized by the Coroner and have been asked to investigate equivocal cases, that is, where the mode of death—whether accident or suicide—is in question. Using procedures which we call the "psychological autopsy" we have learned a great deal about suicide and have at the same time given a valuable service to the Chief Medical Examiner and to the community at large.

We have also been in contact with over fifty health and welfare agencies in Los Angeles County which have telephoned for consultation, or to which we have made direct referrals for extended treatment of some of our patients. At first, social agencies were reluctant to accept even the lowest risk suicidal individuals. However, with referrals that included an evaluation of suicidal potential and the knowledge that consultation by telephone would be readily available, a greater willingness to accept our referrals was noted. Also, the demonstration of our social work staff's work with suicidal persons encouraged social workers in other agencies to do the same. Further, through professional papers, books, and institutes for social work agencies in Los Angeles the SPC shared its knowledge about suicide and pointed the way for these agencies to use this knowledge in professional contacts with suicidal individuals.

At the SPC the social worker performs in a new and exciting role. He works in an area involving life and death and must be receptive to new ideas, for suicide prevention has heretofore been little studied or understood. There is opportunity for creative work in learning more about the nature of suicidal crises and how to deal with them, and he also has the obligation to teach others what he learns.

The social worker accepts an unusually heavy responsibility in working with suicidal crises in that he carries primary responsi-

bility for his cases. He must be able independently to make important clinical judgments, to assess suicidal potential, and to recommend proper action. It is not unusual for him to recommend hospitalization or family separation, and he must be secure enough to trust his own judgment and be able to act quickly in a crisis.

The worker is frequently consulted by members of the other helping professions. These consultations are regarded as just as important as direct requests for help from patients, and their proper handling can be just as effective in lifesaving. Some professionals tend to minimize suicide risk, and this can be especially dangerous; others tend to exaggerate it and need perspective and even reassurance. The role of the consultant is to help his colleagues understand the potential suicide's communication, realistically assess suicide risk, and take appropriate action with the patient.

Most of our casework begins on the telephone. This is a very important instrument in our work, and we use it extensively. We have learned that communication is crucial in prevention of suicide; the telephone provides the lifeline. When communication is indirect or when it breaks down, suicide danger increases.

It is important to understand that people in suicidal crises do call for help. Indeed, we interpret their communications as a "cry for help." Suicidal people are ambivalent about suicide: they wish to die, and they want to be helped. Understanding of this basic fact permits the first step in prevention.

The case of Mrs. A. is illustrative:

> Mrs. A., age 26, telephoned. She said she had just taken twelve sleeping pills but did not know why. While giving names and phone numbers of her husband, friends, and neighbors, Mrs. A.'s voice became weak and slurred, and soon she seemed to pass out while on the telephone. The worker notified the police, and emergency medical aid was rushed to her. During the very act of a suicide attempt, Mrs. A. demonstrated her ambivalence about death by calling for help.

Our technique for handling calls from a patient is to listen, permitting him to tell his story in his own way, carefully noting pertinent information, particularly the specific request being made.

We note names and phone numbers of persons mentioned. If sufficient information is not volunteered, we ask specific questions in a direct, straightforward manner. We need to know identifying data, the current situation, available resources, some aspects of the patient's present psychological status, and his thoughts about suicide.

We have learned that our willingness openly to discuss a patient's suicidal thoughts and plans alleviates his anxiety. He is himself frightened by his impulses and is relieved to find someone who is not afraid to discuss this with him and who is ready to help. It is incorrect to think that talking about suicide with a patient may hasten the act. Many professional people avoid talking about suicide when it is indirectly communicated to them for fear of precipitating an attempt. This is a mistake which often leaves both the worker and the patient troubled and anxious.

About 50 percent of the calls to the SPC are from patients. The remainder are from family or friends, physicians, therapists, police, social workers, and other professionals. These calls are usually to ask if someone about whom they are concerned is seriously suicidal and what should be done. Our job on the telephone is to sustain the line of communication, obtain information, evaluate the suicide risk, and recommend a plan of action. In addition, we want to know the nature and the current status of the relationship between the caller and the patient. Family and friends are advised to contact the patient, discuss their concerns about suicide with him, and ask him to call us. They are told that it is important to communicate to the patient that the "cry for help" was heard and help is being obtained.

With professional persons, our aim is to offer a consultation which will help the professional assume responsibility for working with the situation. If he is not in a position to do so, we ask him to have the patient call us.

We always report back to the original caller after we have made contact with the patient. We encourage callers to stay active in the situation and remain available as a resource. We advise that suicide be openly discussed with all persons involved. Suicide is cloaked in secrecy, which often prevents people from responding to sui-

cidal communications and helping promptly. Yet secrecy and delay can cost a life:

Mrs. B. called about her 55-year-old mother. The mother became acutely depressed one month before, talked of being a burden, wished she would die, and made frequent visits to her physician with generalized complaints, including inability to sleep. One week earlier, she changed her will. Mrs. B. had been concerned about her mother since the depression began but failed to call the SPC. She was especially concerned on the day of her call, because she had not had a telephone call from her mother, as was customary. She was advised to contact the mother and have her telephone for an appointment. Unfortunately, when she went to her mother's home, it was too late. Her mother had taken an overdose of barbiturates and was dead.

Calls to the SPC represent varying degrees of danger, and our task is to get information in order to assess the actual degree. We have learned to do this on the telephone, as well as in the office, based on the following criteria developed from our research and experience:

1. It has long been known that men commit suicide three times more often than women and are therefore higher risks. However, women *attempt* suicide three times more frequently than men, and older persons of both sexes are more serious in their attempt than younger people.

2. If a person has a specific method planned, and the means to carry it through, the situation is more serious than if he merely talks in general terms about various methods.

3. We determine the onset of the crisis. If there has been an acute onset in relation to a specific stress, that usually represents a higher, more immediate danger than would a condition of recurring crises with several prior events similar to the one being described. While the person who chronically threatens suicide has a poor long-range prognosis, the situation for the immediate crisis is less dangerous. From those earlier experiences he will have devised techniques for getting himself through the crisis.

4. Resources are critical in the suicidal crisis. If a person has family, friends, job, or therapist, the danger is reduced. We have found that people do not commit suicide while they are in communication with other persons.

5. Diagnostic impressions are important. If the patient has exhausted his energy, if his thinking and judgment are badly confused, if he is agitated or psychotic, a higher rank is indicated. Also, certain groups have high rates of suicide: alcoholics, addicts, homosexuals, schizophrenics, and those with impulsive characters.

We do not become alarmed about any single criterion with the possible exception of access to a lethal method. Rather, we look at the total picture. If a person rates high on most of the above items, he is a high risk. If he rates low on most items, that is not so alarming.

Mr. M.'s case illustrates our evaluation process. The mother-in-law telephoned about a 34-year-old married man, with two children, who drove over a 250-foot cliff one week before. Miraculously, he escaped serious injury and had only cracked ribs. Although he said it was an accident, he had been making veiled remarks about suicide before and after the incident. He had recently lost his business and felt unable to return to a job he had successfully held before. He was described as withdrawn. He felt that people were watching him, he was not eating or sleeping, and had lost fifteen pounds in one month. His wife and mother-in-law were eager to obtain help for him and were his best resources. Here was a young man reacting to a specific stress, with an acute personality change, who had made a lethal attempt. We assessed it as serious on the telephone, and all three were asked to come into the SPC office.

About three out of four suicidal persons who telephone us do not need to be seen in the SPC office. This is because many of the calls either are not about suicide risk *per se,* or are clearly of low lethal potential. We assess the situation and concentrate our efforts on the potentially more serious cases. We are aware, however, that those patients whom we do not see are in search of some kind of help, which we provide on the telephone. Once we are assured that the suicidal risk is low, we help them to focus on the problem which precipitated the call, because we know that suicidal behavior indicates serious psychosocial disturbance. These are usually marital problems, financial problems, job loss, mental and physical illness—problems which are familiar to community agencies and clinics. We refer the patient to appropriate resources

and encourage him to continue his search for help. We maintain telephone contact by asking the patient to telephone us at planned intervals, thus offering support until he is started in treatment.

We see the more serious cases in the office, usually on the day of the call. We ask persons close to the patient to come in with him, and we take a position of moving into the situation rather than away from it.

In the office we are able to do a more intensive interview and assessment. The aim of this interview is to direct attention to the stress which produced the crisis. Usually, the patient's problems have run together in a hopeless, unmanageable way. We help sort out these problems and try to focus on the most immediate ones, helping the patient to start working on these. We also assure him of our willingness and ability to help. We make our recommendations while the patient and those close to him still have the momentum of the crisis to move toward hospitalization, out-patient treatment, or other recommendations that we may make.

Suicidal behavior occurs within the context of stressful interperson relationships. Thus, a most important resource in the treatment of suicidal crises is the patient's family or "significant others." In addition, there is the complication of secrecy and lack of communication. There are many reasons for involving family or the "significant others." First, the lines of communication must be opened, so that everyone knows the extent and nature of the situation and the patient is made aware that people are paying attention to his cry for help. Second, the responsibility for seeing the patient through the crisis must be shared with those available to help him. We have learned not to deprive the patient of his most readily available resources but include them in our treatment. Family and friends can stay with a patient during a bad night. They can petition for commitment, provide transportation, and do many things that no one else can do. The case of Mr. M. is an instance in point:

The telephone evaluation was confirmed in the office with psychiatric and social work consultation and psychological testing. It was made clear to Mr. M. and his family that this was a serious situation. Re-

sources were mobilized to help through the crisis. A former employer agreed to have Mr. M. return to a less-demanding job, and Mrs. M. took employment to help with income. Medication was prescribed for Mr. M.'s depression. Mrs. M. was advised to observe her husband, and if he did not respond favorably and regressed, she was to hospitalize him. Daily contact was maintained by telephone, and there were frequent office appointments. During the following week, when Mr. M. regressed, his wife had him hospitalized.

Suicide threats and attempts should be understood as communications to "significant others" in the patient's life. The patient is communicating in this way something which he is unable to talk about. He may be trying to say, for example, that he cannot tolerate a marital separation, or that he feels helpless and unable to continue his responsibilities and wants someone else to take over. It is necessary always to involve "significant others" and facilitate more direct communication.

Crises are characterized by disorder, helplessness, and a sense of urgency. They are presented in this way by the patient and it is important that the worker not be overwhelmed by these feelings. We have learned that to listen and help sort out the problems, focusing on those with which the patient can begin to deal, will relieve the feeling of helplessness and disorder.

Many professional people shy away from working with suicidal crises. There are many reasons for this. First, it is difficult to make time for emergencies in already overcrowded schedules. Also, there is heavy responsibility for what is really a life-and-death situation, and this creates anxiety in the worker. There is, too, fear of participating in a catastrophe, but in our experience catastrophes are rare.

Some patients present frustrating and pessimistic problems that create inordinate anxiety in the worker. We deal with this by consulting with members of our own staff, using all the knowledge and skill available to deal with these cases and also to share the burden of a difficult case with others.

There are some rewarding aspects to working with crises situations. Crises present an opportunity for preventive action, and it is important to use this opportunity to offer professional assistance

and help prevent continued suffering and loss of life. Moreover, crises by their very nature are short-lived, and for the worker there is satisfaction in seeing the successful results of his efforts.

For the past five years, the SPC has demonstrated the value of its lifesaving activities in the Los Angeles area. At the SPC, the social worker occupies a pivotal role and carries major responsibility for cases involving life and death. He makes important clinical judgments independently and takes responsibility to recommend action. To work with this kind of responsibility may well represent a new and expanded role for the social worker.

Protective Services for Older People

by MARY L. HEMMY

THE SOCIAL PHENOMENON designated by the phrase "older person in need of protective care" is not new to workers in social welfare, medicine, and law. Only in very recent years, however, has it emerged as a serious community concern meriting concerted study and action. The breadth of this concern became manifest in 1961 when twenty-two states submitted to the First White House Conference on Aging, recommendations regarding the need for adequate protective services for older people. For some years before that something of the extent and ramifications of this problem had been felt by such national agencies as the Bureau of Old-Age, Survivors, and Disability Insurance (OASDI) whose responsibilities touch the lives of large numbers of older persons.[1] Meantime, identification of the problem appeared in other ways: as part of the findings of studies of samples of older people, as in the five-year study of services to the aging conducted by the Community Service Society of New York; [2] as part of findings of studies concerned with mental illness, guardianship, and law; [3] as part of the experience of social agencies offering specialized services for the aging, as United Charities of Chicago [4] and Benjamin Rose In-

[1] Neota Larson, "Protective Services for Older People," Biennial Round Table Conference, American Public Welfare Association, December 5, 1959.

[2] Margaret Blenkner, "Proposal for a Study of the Social Work Component in Protective Care for the Mentally Deteriorated or Disturbed Older Person" (New York: Institute of Welfare Research, Community Service Society, 1958; mimeographed).

[3] Frank T. Lindman and Donald M. McIntyre, eds., *The Mentally Disabled and the Law; the Report of the American Bar Foundation on the Rights of the Mentally Ill* (Chicago: University of Chicago Press, 1961).

[4] Jane Garretson, "A Report of Services for the Aged Project at the End of Four Years Experience" (Chicago: United Charities of Chicago, Family Service Bureau, 1958; mimeographed).

stitute, Cleveland; [5] as part of the efforts of national voluntary agencies, in particular, the National Council on Aging,[6] the American Public Welfare Association,[7] and the American Bar Foundation; and as part of the concern of community planning bodies in meeting the needs of older people, such as the Welfare Federation of Cleveland.[8]

Definitions of old persons in need of protective care have been formulated by the Community Service Society of New York, the American Public Welfare Association, the Welfare Federation of Cleveland, and by Lehmann and Mathiasen.[9] In essence, all define the same group of older people. For the purposes of this discussion, I shall use the working definition developed by the Cleveland Welfare Federation. This definition consists of three general categories of situations:

1. An old person too ill and feeble to take action on his own behalf who is alone or without responsibile persons able, willing, and available to assist him; who lacks proper or necessary subsistence, medical care, or other care necessary to his health; and who is unable to make voluntary application to an agency for support or care

2. An old person alone, with poor judgment and mental confusion, without responsible persons able, willing, and available to provide the special care made necessary by his mental condition

3. An old person alone, or without responsible persons able, willing, and available to care for him, who lacks proper care or who engages in a situation dangerous or injurious to his own life, health, or morals or those of others; and who refuses voluntary aid to correct his condition.

[5] Mary L. Hemmy and Marcella S. Farrar, "Protective Services for Older People," *Social Casework,* XLII (1961), 16–20.

[6] Mary L. Hemmy, "Society's Concern for the Aged Who Need Protective Services," in *Aging with a Future; Reports and Guidelines from the White House Conference on Aging* (Washington, D.C.: Series No. 1, Special Staff on Aging, U.S. Department of Health, Education, and Welfare, 1961), pp. 116–23.

[7] American Public Welfare Association, Committee on Aging, *Guide Statement on Protective Services for Older Adults* (Chicago: the Association, 1962).

[8] Mildred Barry, "Cleveland's Proposal for Older People," report presented at the Tenth Anniversary Meeting of the National Council on Aging, Workshop on Protective Services, October 19, 1960.

[9] Virginia Lehmann and Geneva Mathiasen, *Guardianship and Protective Services for Older People* (New York: National Council on the Aging, 1963).

As is readily apparent, the group under discussion cuts across the entire older population, for it includes all of those who for various reasons are unable to manage their own affairs, personal and financial, in their own best interests, and whose family and friends are absent or unable themselves without assistance to give appropriate help. This includes old people from all socioeconomic groups. The incidence of the problem grows as the older population increases. Paradoxically, it also increases as more old persons have funds at their command over which they exercise discretion and for which they may be exploited, whether such funds consist only of an old age assistance grant, social security benefits, or much more substantial resources.

The numbers of older persons who meet the definition of being in need of protective service are not known. Estimates from two studies [10] indicate that between 5 and 10 percent of the noninstitutionalized urban aged are in need of some kind of protective care. Even assuming that a large proportion of these are receiving necessary protection and supervision from relatives or friends, a substantial number undoubtedly remain who are "unprotected." Some further indication of the numbers of older persons who are unable to manage their own affairs is the fact that some 200,000 OASDI benefit checks are being made to a "representative payee" because the beneficiaries are not capable of managing their own funds. In the opinion of the Bureau of Family Services, a similar number of old age assistance recipients are unable to manage their grants.[11]

Perhaps no social or health agency which deals with adults has failed to encounter this problem. At the same time, relatively few agencies have addressed themselves to the matter of providing the needed services. In part this derives from the complexity of the problems presented, and in part from the nature of the services required.

A significant bench mark was established with regard to pro-

[10] Community Service Society of New York, Study in Services to the Aging (1957–59 data); Syracuse Mental Health Survey of Older People, conducted by the Mental Health Research Unit of the New York State Department of Mental Hygiene (1952 data).

[11] Lehmann and Mathiasen, *op. cit.*, p. xvi.

tective services for older people by two simultaneous events in March, 1963. These were the publication by the National Council on the Aging of the Lehmann and Mathiasen study,[12] and the Arden House Seminar on Protective Services. Sponsors of the seminar included the National Council on Aging, the Family Service Association of America, the Veterans Administration, the National Institute of Mental Health, the American Public Welfare Association, the Social Security Administration, and the Bureaus of Family Services and State Services, in cooperation with the Family Section of the American Bar Association and the Special Staff on Aging of the Welfare Administration of the U.S. Department of Health, Education, and Welfare. Participants included attorneys, judges, nurses, psychiatrists, physicians, social workers, and trust officers. This enumeration of the sponsorship and of the professions of the participants gives some indication of the ramifications of the problem and the services involved in meeting it. Proper protective care for older people almost invariably requires a triad of services—social, health, and legal. Unfortunately, too few receive the triad. All too often the problem is seen as a medical-legal one, with commitment to a mental hospital as the solution. The Arden House Seminar provided the first opportunity for representatives of the professions in the triad of services to study the problem together, to begin to see it in its full dimensions, and to begin to formulate methods of dealing with it in a more coordinated and comprehensive fashion.

Social agencies have tended to back away from the problem for various reasons—philosophical, administrative, and financial—and they are very practical reasons. However, as the matter of the older person in need of protective care and the services he requires is examined in some detail the essential responsibility for social work to participate becomes readily apparent, and the obstacles to such participation, though difficult, are clearly not insurmountable.

To describe something of the characteristics of older persons in need of protective services as well as to elucidate the services required, I shall draw upon some of the findings [13] of a survey of

[12] *Ibid.* [13] Hemmy and Farrar, *op. cit.*; Hemmy, *op. cit.*

protective cases served by the Benjamin Rose Institute, a voluntary, nonsectarian agency exclusively for older persons.

At the time of the survey, 11 percent of the Institute's active case load were protective cases (using the Welfare Federation's definition) at the time they were accepted for service. All in the group were women. The average age at the point of intake was seventy-seven years. Most of them came to our attention through friends, relatives, physicians, lawyers, and clergymen rather than through community agencies. None had herself applied to the agency. The great majority were living essentially independently: more than half lived alone in houses or apartments; a few lived in their own homes with roomers; a few, in residential hotels for women. Only two lived with family members. Others lived in boarding homes, homes for the aged, or on a room-and-board basis in private homes.

As a group they were not economically destitute although in many instances financial resources were not sufficient to meet the client's needs. Almost one half received OASDI benefits; about one fourth had savings or property; about one fourth received financial help from relatives; 16 percent were still earning some income; only 13 percent received public assistance. Almost all were in need of medical care and health supervision.

Of the total of fifty-eight, only eight had legal guardians, appointed before or subsequent to the initiation of agency service. Seven had been treated in mental hospitals at some time; two were in mental hospitals at the time of the survey; the other five had improved sufficiently to be placed in nursing homes. Thus these were people of advanced years, essentially alone, in need of health care, with funds and other assets to be conserved who, because of physical or mental deterioration or severe personality problems, were unable to manage their affairs in their own interests or to seek necessary help.

A sample of the total was examined in more detail. Of these, the majority had been living in an increasingly deteriorating way from three months to many years. They exhibited varieties of illnesses and physical disabilities. Failing memory and judgment had resulted for some in gross wasting of financial resources or exploitation by unscrupulous persons. Some presented serious problems

for themselves and the community—extreme malnourishment; attempted suicide; health and fire hazards caused by appalling accumulations of filth and debris in houses or apartments. In many instances efforts of friends and neighbors had failed because of the resistance of the old person to see a physician, to have housekeeping help, to move to an environment which would provide the care needed, or to take other steps which would improve the situation.

From this rather brief description, perhaps some of the philosophical problems relative to taking responsibility for service to this group of people become apparent. The helplessness of such old people and their extensive needs and frequent lack of both internal and external resources mean that the person or agency giving assistance must assume responsibility of large proportions. They do not and often cannot seek the help they need. Someone must go to them. Some are resistive and rejecting of help. A central and delicate question becomes the matter of the individual's right, on the one hand, to live and die as he wishes versus the community's responsibility to protect him (and sometimes itself) from the results of his failing or distorted judgment. For social workers this question raises at least three issues: (1) the matter of actively initiating service to adults who have not sought service and who may verbally reject it; (2) the individual's right to self-determination versus his right to protection from himself and others; (3) the use of various kinds of authority.

The first issue is rather easily resolved if one views this group of people, not in the context of what have become traditional expectations of, and methods of work with, adults, but rather as a group unable to act in their own behalf whose needs must be met and whose rights must be insured. Methods of reaching them and assisting them must be governed by their particular capacities, limitations, and needs. An agency which provides protective services must actively reach out to the individual, and this requires a somewhat different orientation to the offering of service, and certainly a different organization of agency services from what is now generally customary.

With regard to the matters of self-determination and use of authority, Wasser, in a most penetrating and closely reasoned analysis,

points out that "it is essential to distinguish between what constitutes *invasion* of rights and what constitutes *preservation* of rights," and that "rigid adherence by the social worker and agency to the concept of client self-determination when client capacity for self-determination is seriously lacking may unwittingly become abnegation of service." [14] She points out further that authority and its use are constant components in all social work services, that is, professional authority, or "the power to influence" which derives from professional knowledge, ethics, and competence used to achieve betterment for the individual or community. In Wasser's view, the concept of professional authority includes, not only the idea of influence, but that of active intervention as well, including initiating legal proceedings in the client's interest if need be. This conceptualization placed within the frame of reference of the broad purposes and goals of social welfare provides a firm basis for agency boards and their staffs to assume responsibility for providing protective services.

As a part of a demonstration-research project on protective services for older people being undertaken by Benjamin Rose Institute, a further tentative conceptual definition of the problem—"being in need of protective service"—has been formulated. Need for protective service is seen as a function of competence (psychological, physiological, and social) in relation to environment, that is, the degree of protection afforded by the environment.[15] Thus assessment of function and environment, and of function within environment, becomes the determinant as to whether professional intervention is required, and the kind and extent of intervention and services needed. It is in this connection that the triad of professional services becomes most significant, for assessment of function and environment as well as the provision of needed services requires the coordinated professional competencies of medicine, law, and social work in varying combinations. The practitioners involved must have knowledge of the functions, competencies, and

[14] Edna Wasser, "Responsibility, Self-Determination, and Authority in Casework Protection of Older Persons," *Social Casework,* XLII (1961), 263.

[15] Margaret Blenkner, "Protective Services for Older People; Progress Report on Demonstration-Research Project" (Cleveland: Benjamin Rose Institute, 1963; mimeographed).

methods of work of one another. For the social worker, for example, this means more than usual familiarity with the purposes of law and the functions of lawyers, with various forms of fiduciary relationships, with laws of guardianship and commitment, and the implications of such legal matters both for protection of and loss of an individual's rights.

From the viewpoint of a social agency, protective cases present certain characteristics which carry corollary implications for the organization and administration of agency services, for the professional and personal requirements of the worker and his methods of work, and for the availability of needed resources and services. As Lehmann and Mathiasen point out:

> The services themselves will in many respects be the same as those provided by any casework and counseling agency. In a protective service, however, the agency through its staff must be prepared *to act* when necessary in addition to giving advice.[16]

Action may range from trying to persuade a client to accept a given course of action to the extreme of initiating a petition for appointment of a guardian. Action—using professional authority, and in the face of what may appear to be varying degrees of resistance on the part of the client—may include counseling and assistance in management of funds; instituting medical care, the services of a public health nurse, homemaker service; or moving the client to an environment offering needed care and help.

A protective case usually comes to the attention of the agency at a point of crisis when immediate action is required. Central to the solution of the problem is the fact that the caseworker must: (1) gain access to the old person without further frightening what is often an already frightened and confused person; (2) establish a relationship which will permit accurate assessment by the worker (and physician and attorney, if necessary) of the client's social, psychological, and physical functioning and assessment of his environment (3) further develop the relationship within which the worker will take such actions with and for the client as may be needed. These steps are often difficult and time-consuming. The tempo must usually be slow. Frequent visits are necessary, and

[16] Lehmann and Mathiasen, *op. cit.*, p. 117.

many personal services must be carried out to enable the old person to develop confidence in the worker as a person genuinely concerned about him and trustworthy to help him make decisions or, if need be, to make decisions and take action for him. The judgment of the worker in choosing and timing significant kinds of intervention is crucial. It is our experience that it is possible through such a relationship to carry out actions essential to the client's well-being, when he may appear to disagree with the decisions reached, and to achieve outcomes which the client actively accepts with relief and satisfaction.

To move through the various phases of protective service in an urgent situation, to the point where resolution of the major aspects of the problem is achieved, may require almost the full time of the caseworker for a lengthy period. Further, such clients usually require continued assistance in some degree for the remainder of their lives. For many, the worker and the agency often stand in lieu of family. This responsibility includes providing many kinds of essential personal services, dismantling homes and apartments, disposing of personal possessions, arranging for burial, and doing other chores usually assumed by family or friends. We use nonprofessional personnel, who work closely with the caseworkers, to carry out many important but time-consuming tasks. At various points access to a physician or a lawyer may be essential, either for direct assistance to the client or for consultation to the caseworker and the agency, or both.

The nature of the protective case is such that many kinds of resources must be readily available, to be used flexibly and immediately. In addition to medical, psychiatric, and legal services, these include nursing care, hospital care, nursing home care, housekeeper or homemaker services, drugs, ambulance transportation, and funds for immediate needs such as food, clothing, and rent. Mobilization of these resources is essential, and their availability must be insured if the caseworker is to function successfully in these difficult and precarious cases.

For the caseworker, protective cases require diagnostic ability of a high order; perceptiveness about, and skill in, nonverbal as well as verbal communication; a personal freedom combined with

warmth and respect for the client which permits ingenuity in finding ways to provide psychological comfort and security at the same time that he may have to bring about disquieting changes in the client's life. He must know how to deal directly with a variety of practical problems, be willing and able to take needed action, and be able to accept the necessary dependency of the old person upon him for an indefinite period, handling it in a manner healthful both for the client and himself.

Clearly, providing protective services involves heavy responsibility for the agency and its staff. One may well question how success is measured in such cases. In the sample to which I have referred, we found that in some cases symptoms of gross pathology were reduced and the individual's functioning improved, given the conditions for diagnosis, treatment, and auxiliary resources which I have mentioned. In others, the level of personal functioning of the client was sustained over many years in his usual environment through adding various kinds of supportive services and maintaining a relationship with the agency. Further, protective services enabled the majority to remain in, or return to, life in the community rather than being cared for in mental hospitals.

Much is yet to be learned about persons in need of protective services and about the kinds and manner of intervention needed and their effectiveness. In particular, much is to be learned about the factors underlying this problem which will open ways to its prevention.

Perhaps the basic requirement for an agency to invest time, resources, and personnel in providing protective services is the valuation held for the cumulative experience of living, for the endless capacity of the human being for change and adaptation, and for the inherent dignity of each person to the last moment of his life. Correspondingly, the methods of giving service are directed toward supporting and maximizing such capabilities as the individual has for decision-making; toward helping him to participate to the extent possible in decisions reached, plans made, and actions taken; and toward insuring that no part of the independence of which he is capable be taken from him.

Definition, Origin, and Treatment of Underachievement

by JANE W. KESSLER

UNDERACHIEVEMENT IS A SPECIAL national concern of the moment. In contemporary American culture, education is regarded as the magic key to success. The dawn of the Space Age brought education and higher intellectual achievement to the forefront of national attention. Educators, parents, and, finally, children have felt the heat of educational acceleration. It has become clear that not only is the supply of nuclear physicists inadequate, but also the demand for unskilled laborers is fast dwindling. For practical reasons, parents and teachers are alarmed when a child shows difficulty in academic learning. When a child fails in school, or consistently falls far short of his intellectual potential, the problem is almost a matter of dollars and cents. The parents worry: "Will he go far enough in school to be able to get a good job?" From a broader perspective, the educator asks such questions as: "Will he be a school dropout and potential delinquent?" "Is valuable talent going to waste—talent which could preserve our way of life?"

School learning difficulties have long been a frequent reason for referral of school-age children to child guidance clinics. Gilbert's survey [1] of referral problems reveals that academic difficulties are the most common single reason, representing 45 percent of the total. There are no statistical reports sufficiently recent or complete to reflect the societal changes of the past decade. Including the referrals to psychological services within the public schools as well as referrals to child guidance and child psychiatry clinics under

[1] G. M. Gilbert, "A Survey of 'Referral Problems' in Metropolitan Child Guidance Centers," *Journal of Clinical Psychology*, XIII (1957), 37–42.

hospital or community auspices, it is probable that academic difficulty is given as the presenting problem for three fourths of the children who are first referred in the age bracket between eight and fourteen years. A small example of present-day attitudes is given by the following anecdote. A nine-year-old boy was referred for psychiatric diagnosis because he daydreamed and pulled out big bunches of his hair in class. In making the referral, both teacher and parent pointed out that he was doing very well in his academic studies, "but if the daydreaming and hair-pulling keep up, perhaps his schoolwork will be affected." Apparently the only reason for concern was the possible damage to his grade average.

As an educational phenomenon, a learning difficulty is an inadequacy in scholastic achievement, measured by an academic norm currently in vogue. Changing the academic standards may alter the report card without making any basic change in the individual. As an emotional symptom, a learning difficulty is a sign of functional impairment. In a learning difficulty of emotional origin, there is a restriction of some ego function: a difficulty in absorbing new knowledge (learning in its literal meaning); a difficulty in holding knowledge (memory); a difficulty in synthesis of knowledge (judgment and comprehension); or a difficulty in giving out (producing work). Of course, these ego restrictions are not mutually exclusive and may appear in various combinations. However, to assert that an academic difficulty is emotional, it must be established that one or another of these ego restrictions is operative. A child may be failing in school because of poor health or sensory deficit, because of poor teaching, or because of scholastic expectations which are unrealistic for his particular level of mental ability.

More articles have appeared on the subject of learning disturbances than on any other form of childhood psychopathology, with the possible exception of juvenile delinquency. Only recently have authors attempted to define their terms. Many times, the term "learning disorder" is applied to a total inhibition of intellectual functioning, that is, a depression of intelligence from emotional causes, as in psychogenic retardation. At other times, it is used synonymously with "underachievement," that is, a discrepancy between school performance and measurable intelligence. And

within the general category of underachievement there are learning difficulties which are concomitant with such other gross symptoms as delinquency, seizures, childhood schizophrenia, and severe obsessional states. Any personality disorder which has a pervasive effect on the ego or superego is likely to have school difficulties as one inevitable consequence. This is a different picture from that of primary neurotic learning inhibition where the learning difficulty is the major symptom.

It seems deceptively easy to define underachievement until we look closely at the three components involved: (1) the measurement of potentiality; (2) the measurement of achievement; and (3) the degree of discrepancy to be considered significant. There is no need to belabor the difficulties which are involved in the measurement of intelligence or potentiality. This would lead into problems of choice of tests, constancy of the IQ, and the nature versus nurture controversy regarding the development of intelligence. This is a field in and of itself. In identifying underachievement one can say that a "false positive" is highly unlikely although it is possible to get a "false negative." In other words, if there is a significant discrepancy in measured intelligence and achievement, it is worthy of serious consideration. On the other hand, if there is no such significant discrepancy, it is conceivable, though not certain, that the measured intelligence and measured achievement are both affected by the same factors to a like degree, thereby masking a learning disorder of emotional or environmental origin.

Turning to the second component of achievement measures, we find two main ways of measuring achievement in school children: scores on standardized achievement tests and teachers' grades or reports. It is important to recognize that a group of students picked as underachievers on the basis of school grades will not be the same as those picked as underachievers on the basis of achievement test scores.[2] The children who are identified as underachievers on the basis of below-expectancy achievement test scores have failed to learn academic skills or acquire information. This group includes

[2] Milton J. Cohler, "A Comparative Study of Achievers and Non-Achievers of Superior Intelligence," *Summaries of Doctoral Dissertations,* Northwestern University, VIII (1940), 74–79.

cases of specific disabilities, such as reading problems and the like. In all these cases there has been a failure in learning, partial or total, relative to the rate of learning expected from the measured intelligence. In contrast, those children who score well on achievement tests and do poorly on grades demonstrate that they have been learning what they should. The low grades may indicate an inability or unwillingness to produce the required work, an inability or unwillingness to cooperate with the teacher, an inferiority in performance relative to the rest of his classmates, and so on. On the face of it, it seems that the psychological cause-and-effect for the nonlearning group is more serious than for the nonproducing group. The latter are in possession of the requisite skills and information to use when there is a change in their motivation or situational circumstances. The nonlearners become increasingly handicapped as time goes by; a problem which may have started from purely psychological causes, in time becomes a realistic problem which cannot be overcome by purely psychological means alone. It is not enough to say that underachievers chosen by these two criteria are different; careful longitudinal research is needed to demonstrate if the prognosis is in reality more favorable for the one than for the other, as one would think on a commonsense basis.

Finally, we should consider the problem of the degree of discrepancy between measures of intelligence and achievement. Most people do not do as much or as well as they could. It is very hard to decide at what exact point this falling short ceases to be merely human and becomes an individual problem. Just from inspection one can appreciate that a ten-year-old youngster of average ability who performs like a second grader in reading, writing, and arithmetic has a serious problem. But suppose this same youngster performs like an average fourth grader? Then the decision whether to classify him as an underachiever is much more difficult and arbitrary. The statistical problems inherent in the definition of underachievement are more important in the research setting than in the clinical setting, where one is likely to see the obvious, extreme cases. Estimates as to the number of underachievers in a school-age population will vary in direct relationship to the definition that has been applied. One reads statements to the effect

that 50 percent of children of superior mental ability are underachievers, which naturally arouses a feeling of alarm. Such estimates are based on a rigid, stringent criterion of matching achievement and intelligence. One can control the number of underachievers by the manipulation of test scores. This does not mean that all of these children are psychologically "in a bad way" and destined to be dismal failures.

It is difficult to review the extensive research that has been reported on underachievers because there has been no commonly accepted definition. The following highlights are only some specific points which the author has picked out of the confusing welter of published material:

1. Underachievement can occur at any mental ability level.

2. Underachievement is predominantly a male problem. No matter where the studies have been done, or what method has been used, there is universal agreement that a greater number of boys than girls are underachievers. Also, the timing is different. Chronic male underachievers tend to display underachieving behavior in the earliest grades, while females, in general, begin to demonstrate serious underachieving behavior in their late elementary or junior high school grades.[3]

3. There has been a steady trend toward looking at younger and younger age groups for the beginning of underachievement. Shaw and Brown,[4] among others, report that the problems of the college underachiever with superior ability do not originate in the college environment. Most of these students had a record of underachievement dating back to high school. Frankel [5] reports that underachievement among intelligent high school boys can be predicted from their junior high records. In a similar vein, Shaw and Grubb [6] conclude that underachievement does not have its origin

[3] Merville C. Shaw and John T. McCuen, "The Onset of Academic Underachievement in Bright Children," *Journal of Educational Psychology,* LI (1960), 103–8.

[4] Merville C. Shaw and Donald Brown, "Scholastic Underachievement of Bright College Students," *Personnel and Guidance Journal,* XXXVI (1957), 195–99.

[5] Edward Frankel, "A Comparative Study of Achieving and Underachieving High School Boys of High Intellectual Ability," *Journal of Educational Research,* LIII (1960), 172–80.

[6] Merville C. Shaw and James Grubb, "Hostility and Able High School Underachievers," *Journal of Counseling Psychology,* V (1958), 263–66.

in the high school classroom but that it is a problem which the student brings with him, at least in embryo, from junior high school. Barrett [7] was able to trace the first appearance of underachievement in his group of gifted secondary school students back to the fifth grade. Krugman and Impellizzeri [8] identify grade three as the crucial point when reading and other school difficulties first become apparent. Shaw and McCuen [9] established an even earlier age of onset for a group of underachieving boys in the eleventh grade. Even in grade one these boys had lower grades than the later achievers. However, it was not until grade three that this difference became statistically significant.

All authors emphasize the need for early identification for remedial measures to be successful. Everyone who is studying underachievement finds that the causes predate the particular age period with which they are directly concerned. Everyone thinks that treatment would be more effective if only it were started earlier. It is easy to sympathize with the pleas for early detection. Nevertheless, it is still a question at what age and by what means the chronic learning problem can be recognized. Retrospective studies tell us that underachievers show early signs of trouble, but we need to know how many children who show those same signs at the same early point do not become underachievers at a later age. Longitudinal research is needed to show which kinds of underachievement leads to what final results, not only in school, but also in vocational and community living after school. Without some scientific care and caution, there is danger of getting caught up in a whirlpool of excitement and perfectionism where every other child is regarded as an underachiever in dire need of special help.

4. A fourth area of research has been the description of differentiating characteristics of the underachievers. As might be expected, the parents of underachievers tend to have less education than do the parents of the achievers. The parents of the achievers also show a greater inclination to push their children toward

[7] Henry O. Barrett, "An Intensive Study of 32 Gifted Children," *Personnel and Guidance Journal,* XXXVI (1957), 192–94.

[8] Morris Krugman and Irene H. Impellizzeri, "Identification and Guidance of Underachieving Gifted Students," *Exceptional Children,* XXVI (1960), 283–86.

[9] Shaw and McCuen, *op. cit.*

achievement, not only at school, but in other areas as well. The parents of underachievers not only appear to demand less in the way of specific performance from their children, but also to make their demands at a later date. Kramer [10] shows that there was more expressed difference of opinion as to how to raise children between the parents of an underachiever than between the parents of the achievers. So far as the children themselves are concerned, there has been conflicting evidence as to whether they are less or more anxious, more or less negative in their self-concept, and so on. Some interesting studies at the college level have indicated that achievers are more realistic in setting goals for themselves. Mitchell,[11] for instance, finds that underachievement is associated with a high level of aspiration and a gross overestimation of actual performance. Worell [12] finds that the high achiever characteristically sets a level of aspiration which is close to his previous performance and does not expect to achieve considerably beyond his previous efforts by exerting himself to the limits of his capacity.

The list of studies of this order is almost endless, but the results are often inconclusive or offer little beyond a superficial personality observation. Partly, this is because of methodological problems of definition and measurement. But in addition, contradictory findings are inherent in the very nature of the problem studied. It is naïve to expect that underachievement results from any single cause. Underachievers do not form a homogeneous group any more than, say, a group of traffic offenders. It is important to consider underachievement as a problem with many causes. We should look for ways to subdivide the group according to degree and kind of symptom as well as etiology.

I turn now to comments which are based on clinical observations of individual children rather than on large-scale research investigations. Most of this experience has been derived from diagnostic

[10] David P. Kramer, "Interparental Differences of Opinion as Manifested in Children's Academic Achievement" (unpublished doctoral dissertation, Western Reserve University, 1962).

[11] James V. Mitchell, Jr., "Goal-setting Behavior as a Function of Self-Acceptance, Over- and Underachievement, and Related Personality Variables," *Journal of Educational Psychology*, L (1959), 93–104.

[12] Leonard Worell, "Level of Aspiration and Academic Success," *Journal of Educational Psychology*, L (1959), 47–54.

and counseling work with families in moderate circumstances. The underachieving child from a culturally impoverished home background rarely finds his way to individual study. He is usually lost in a group of underachieving children. There is no diagnostic problem involved when a child of an impoverished family who takes no interest in his school career does poorly in school. The problem is to find an effective treatment. Remedial action has to proceed along a broad sociological front. However, values are not homogeneous within a social class structure. It cannot be assumed from the home address that a specific family sets great store by intellectual achievement. Considerable stress may be put on material possessions and external appearances. An intellectual attainment, even in this day and age, is not a straight-line way to riches. A common expression indicates cynicism about the value of knowledge: "It's not what you know that counts, it's who you know." A child brought up on this general philosophy naturally looks for shortcuts—intellectual "contacts" rather than intellectual "contents."

Parents alone cannot create a serious learning disorder. In almost every case there is some constitutional compliance from the child. This constitutional compliance may be in the form of an organic factor or a temperamental predisposition toward passivity or inability to tolerate frustration. On the other hand, there are instances where the parents contribute more than an even share to the problem.

Some of the specific mechanisms by which parental behavior can interfere with the child's ability to use his intelligence merit discussion. Obviously, this list is representative rather than exhaustive of all of the possibilities. Also, the mechanisms are by no means mutually exclusive. It is entirely possible for one set of parents to be involved in more than one way in the production of a learning inhibition.

1. *Early childhood training.*—A child has many experiences with education and instruction before he enters school. His parents are his first teachers. It is easy to see that if his early training has been coercive, there is likely to be a residue of resentment against authority figures. These feelings, which have their origin in the parent-child relationship, are easily transferred to the teacher-child

relationship. The teacher then inherits an unwilling pupil, one who resists her authority, her knowledge, and her demands for performance.

There is another side to this same coin: expecting too little rather than too much. Training experiences of the first few years provide the prototypes for later learning experiences of a more formal nature. Toilet training illustrates the principles involved. If toilet training is done very early, the child is conditioned on a physiological, involuntary basis; he is simply a passive partner. On the other hand, if it is delayed until the child trains himself, the mother is the passive partner. The child does not learn to work at something for the sake of winning the approval of someone else. The mother's neutrality means that she has not been involved in the child's motivation. If she shows no pride in his accomplishment, then the child has no special pride either. It should be pointed out that the mother who delays in one crucial area of training, for whatever reason, is likely to delay in other areas, such as self-feeding and self-care in dressing, bathing, and toileting. Some time between birth and maturity every normal child learns these skills, but it makes a difference when and why. If he learns them belatedly, out of sheer necessity, the experience does not particularly contribute to the development of ambition. If these early achievements have been encouraged, recognized, and rewarded, the child incorporates the mother's sense of pride and can be proud of himself for a job which he does well.

2. *Parental management of childhood curiosity.*—The parents have ample opportunity, not only to teach their child to perform, but also to teach him to wonder. Although curiosity is thought of as something which everyone favors, this holds true only for intellectual curiosity on impersonal topics. The more troublesome subjects which are of concern to an intelligent young child include questions regarding sex differences, the origin of babies, death, religion, and so forth. It is easy for adults to underestimate the thinking power of preschool children. It is assumed that they think or feel only that which they put into words. Parents tend to ignore those signs of curiosity which would lead to their embarrassment or discomfort. There are other kinds of questions,

too, which are discouraged by parents. For instance, the author has found that a significant number of children with learning difficulties have had the experience of serious illness in a close member of the family. Even though attempts are made to keep illness hidden from a child, he reacts to the change in the emotional atmosphere of the home. He senses the worry and anxiety, and if the subject is taboo, he is afraid to ask questions or to share his worries with anyone.

Hellman [13] describes the treatment of three mothers of children with intellectual inhibitions to demonstrate the close bond between mother and child and how the mother's lying and secretiveness force the child to seem stupid and incurious. In these particular cases the secret had to do with marital infidelity. Inhibition of curiosity on any emotionally charged subject—sex, marital conflicts, antisocial escapades, alcoholism, serious illness—can be displaced onto other topics, even those remote from the original source of conflict. Unconsciously, the child says, "OK, if I have to stop thinking about this or that which I would really like to understand, the only way I can do it is to stop thinking altogether." Curiosity cannot be compartmentalized and restricted to the safe subjects presented in school.

3. *Parental management of childhood aggression.*—The importance of ambition and curiosity in school performance is clear. It is not immediately obvious how aggression connects with learning. Often, aggression is considered only in terms of hostile affect, or antisocial behavior. It is used here in a broader sense, almost synonymous with activity. Learning is work which requires the expenditure of energy; the child cannot be an inert, passive recipient of instruction. He must have the energy to be inquisitive, to penetrate, and to persevere against obstacles. There are several lines of evidence to suggest that the overtly aggressive child has a better prognosis, at least from the intellectual standpoint, than the overly submissive child. In his comparative survey of 100 learners and 100 nonlearners referred for psychiatric consultation, Harris [14] reports

[13] Ilse Hellman, "Some Observations on Mothers of Children with Intellectual Inhibitions," in *Psychoanalytic Study of the Child* (New York: International Universities Press, 1954), IX, 259–73.

[14] Irving D. Harris, *Emotional Blocks to Learning* (Glencoe, Illinois: Free Press, 1961).

that learning difficulties are associated with both extremes of aggressiveness and submissiveness, but the overly aggressive nonlearner is intellectually brighter than the overly submissive nonlearner. This finding is corroborated by the data of Sontag, Baker, and Nelson [15] from individual case studies of children who showed marked increases or decreases in measurable intelligence over a period of time. According to these studies, the passive, infantile dependence pattern led to a decreasing level of the Binet performance; the aggressive, competitive, independent pattern, on the other hand, led to progressively advanced Binet performance. Sperry, Ulrich, and Staver remarked that "the boys whose activity in school annoys the teacher and interferes with their work seem to be in a psychologically more favorable position eventually to achieve in school." [16] This is worth special note because the overtly aggressive, overactive boys are usually the despair of their teachers, while the passive, compliant youngster often elicits a great deal of sympathy.

The passive child is remarkably difficult to rescue, and it takes time to appreciate the subtle difficulties involved. He appears agreeable and willing but he does not keep anything in mind. He makes no effort on his own initiative; he forgets his interim assignments; and so on. Study of the home situation of these youngsters may show that the parents have required denial of all hostile feelings or aggressive action. Many times these passive youngsters have been taught, directly and indirectly, by parental example to submit to almost any indignity for the sake of being liked. With the total renunciation of aggression, there is a corresponding depletion of energy and a pathetic absence of ambition to succeed.

4. *Interplay between mothers and sons.*—Youngsters frequently have a pattern of behavior which involves them with their mothers on any number of issues at home as well as at school. They dawdle while dressing in the morning; they mislay their belongings; they do not finish their club projects; they do not practice on their musi-

[15] L. W. Sontag, Charles T. Baker, and Virginia L. Nelson, "Personality as a Determinant of Performance," *American Journal of Orthopsychiatry,* XXV (1955), 555–62.

[16] Bessie Sperry, David N. Ulrich, and Nancy Staver, "The Relation of Motility to Boys' Learning Problems," *American Journal of Orthopsychiatry,* XXVIII (1958), 640–46.

cal instruments; they bicker with their siblings; they do not brush their teeth or take a bath without nagging; they are sloppy and messy at the table. They rarely get into serious trouble and behave better away from home. Briefly, parents and teachers describe such a child as irresponsible and immature and remark, "You have to keep after him all the time." In disposition the child himself may be happy-go-lucky even though he complains that he is nagged and hounded constantly.

The clinical question is whether the child himself requires this close surveillance and supervision, or whether it is provided gratuitously. It is clearly a problem of interaction: the mother feels that her continued close attention is justified by the child's indifference and indolence; the child, in his turn, feels that since his mother is always after him anyhow, it might as well be for some good reason. It is equally unclear to both parties as to who has the real responsibility for what. Despite the mother's protestations to the contrary, she behaves as if she were responsible for the child's successes or failures, and the child agrees with her behavior rather than with her words. One fourth grader was honestly indignant when he was reproached for his failing grade in spelling. His explanation to his mother was, "It's not my fault. You forgot to take the spelling lists out of my coat pockets." It is natural for mothers to feel a narcissistic involvement with the successes or failures of their children. It is a question of degree. The process of psychological detachment is a difficult one. But as long as the parent continues to feel that he or she is the one who is responsible for the child's performance, the parent feels the anxiety and the motivation that more appropriately belong to the child. To some extent, this is fostered unwittingly by teachers who look first to themselves and then to the parents for an explanation of a child's unsatisfactory progress. The parent is afraid to withdraw her forcefulness lest the school personnel consider her lax or disinterested. Parenthetically, it should be stated that a parent can be interested and supportive without forcing. It is a question of who takes the initiative and who feels the shame of failure or the pride of success.

In an extreme form, the interplay provides the basis for the acting out of unconscious aggression on both sides. The child may feel that he is loved or unloved simply in terms of his level of per-

formance; that the parent cares about nothing else. In one way, this gives a child a sense of insecurity; on the other hand, it also provides a powerful weapon against the parents. Refusal to do well in school can be a way of getting even without any conscious or overt expression of aggression. It is a particularly efficient symptom because the child feels no inner guilt; the symptom itself brings enough punishment from the outside so that he does not punish himself with guilty feelings. The parent-child interplay around the subject of schoolwork is reminiscent of the interplay which may go on with preschool children around eating. Although the parent can provide the invitation, the attractive opportunity, the example in behavior, and some limitations, he can force a child neither to eat nor to learn. Basically, both functions arise from the inner drives of the child—hunger in the one instance; a combination of curiosity, desire to master the environment, wish to grow up, and desire to meet high standards in the other.

5. *Fathers of sons with learning problems.*—In most reports of parental contributions to childhood psychopathology, the mother is the central figure of study and the father is a shadowy creature in the background. Particularly in the case of learning problems of boys, the father's part seems fully as important as that of the mother. Grunebaum, Hurwitz, Prentice, and Sperry [17] make some interesting observations of the fathers of sons with primary neurotic learning inhibitions. These are based on eighteen elementary school boys, all from homes without gross social pathology. The learning problem was the major complaint in each case, although enuresis was also present in nine of the eighteen. Although the social class level of the eighteen fathers was predominantly lower-middle and middle-middle class, the fathers themselves regarded their achievements as failures. They devalued the importance of their work and described it as tedious, insignificant, and stultifying. The authors remark: "The readiness of these men to accept a self-derogatory role with an attitude of helpless resignation was impressive." [18] In contrast, the husband perceived his wife as a superior person, an opinion shared by the wife. Whether in reality the

[17] Margaret Galdston Grunebaum, Irving Hurwitz, Norman M. Prentice, and Bessie M. Sperry, "Fathers of Sons with Primary Neurotic Learning Inhibition," *American Journal of Orthopsychiatry,* XXXII (1962), 462–73.

[18] *Ibid.,* p. 464.

wives were so much more able than the husband was questionable.

This kind of family situation is conducive to the formation of a learning problem for a number of reasons. First, there is an unspoken expectation on everyone's part that the child will fail also, despite the conscious statement to the contrary. Secondly, the possibility of the child's not failing, that is, succeeding in a way the father could not, may bring the child into a new set of conflicts—jealousy in the father, oedipal guilt in the child, and excessive admiration or resentment from the mother, depending on her neurotic structure. These reactions to a child's superior achievement do not come if the father's failures were determined by outside events rather than by his own personality difficulties. The immigrant father, the father who had to start work at an early age, or the father who never had a chance to attend school can enjoy his son's success vicariously, thinking all the while that the same could have been his except for unlucky circumstances. But the father who considers himself a failure despite ample opportunity to be otherwise has much more conflict about his son's achievements.

Still a third way in which this sort of family constellation affects the son's learning performance is in the identification process. The boy's view of achievement, competition, and masculinity is distorted so that femininity is associated with achievement and competitiveness and the life of a grown man has no drawing power. If the father obviously dislikes his work, there is nothing for the boy to anticipate except more tedium and onerous responsibility. The boy is on the horns of a dilemma: to follow the passive, weak, but masculine role of the father; or to be more active, competitive, and achieving in the aggressive manner of the mother. With such a conflict choice, passivity as the easier of the two alternatives usually wins out.

In discussing the influence which parents have on the learning difficulties of their children, the emphasis has been on interrelationship factors. Learning is an interpersonal process involving someone in the role of teacher and someone in the role of learner. It requires the acceptance of the authority of the teacher and the permission and encouragement to be actively curious, to be knowledgeable, and to be successful. In this, the child responds in accord-

ance with his experience in the preschool years. He also reflects the conscious and unconscious wishes of the parents, and it is easy to see the importance of the identification with perceived parental behavior. This might lead us to the simple conclusion that if we change the parents, we will change the child. In some cases we can do exactly that. In other cases, we fail either because the pathology of the parents is hard to reach, or because the problem has become internalized in the child. In the latter instance, the learning inhibition is a defense against anxiety, the source of which is unconscious to the child.

What is the nature of the social worker's contribution to the identification and treatment of underachievement? The answer to this question should be considered in two parts. First, the social worker should share the concern of all educators for the educational disabilities of children of limited background. The essential need of the large cities to improve the education of great numbers of pupils of limited background is increasingly urgent. Taber quotes a 1961 report from superintendents of fourteen cities that classifies one out of three children as being of limited background compared with one out of ten in 1950.[19] These are underachievers of low aspirational level, coming from families with limited vocational and economic competence, low social expectancy and disrupted family patterns, who reside in highly congested and deprived neighborhoods. Many urban school systems have initiated programs for raising achievement and aspiration levels, and all concur in stressing the importance of involving the families. These are the same hard-to-reach clients who have tested the ingenuity of social casework practice in dealing with delinquents, unwed mothers, public welfare clients, and the like. The experience of social workers should be shared with the educators who are struggling to solve the educational problems of cultural retardation and the school dropout. Of special usefulness are the group work techniques evolved by settlement workers and the like.

However, the vast majority of school social workers are employed by suburban school systems where the focus is on the child who

[19] Robert C. Taber, "The Critical Dilemma of the School Dropout," *American Journal of Orthopsychiatry,* XXXIII (1963), 507.

stands out from his peers by reason of his poor achievement. Here, the social worker should collaborate with the teaching staff and psychologist in making the educational distinction between the nonlearner and the nonproducer and in evaluating possibilities for depressed intelligence on the basis of environmental or emotional factors. The social worker should participate in the selection of those with chronic learning problems who warrant careful individual study. It has been mentioned that the third grade is a crucial year for the identification of such cases. This brings the school social worker into the time-honored roles of history-taking, clinical categorization, interpretation, referral, and parent guidance. Certain complications arise out of the setting in which these functions are carried out. At first, the parents may consider the social worker's interest as an intrusion on their private affairs or as an attempt to absolve the school of responsibility, but the social worker can afford to take her time because the child is not going anywhere. Superficially, learning problems can be grouped in four clinical categories, useful in considering possible dispositions: (1) children who are living under home situations of unusual stress; (2) children whose school problem is but one of many overt symptoms; (3) otherwise well-adjusted children of normal intelligence, who have little aptitude or zest for scholastic activities; (4) children of above-average intelligence whose school problem is apparently a single one without an obvious external cause. The first and second probably require referral to an outside agency; the third and fourth may be assisted or appropriately studied further in the school setting. Interpretation and counseling the parents will require a good knowledge of educational tests, an intimate understanding of the learning process and how it is affected by differences in mental ability, parent and teacher attitudes, and the psychology of the child.

Perhaps one of the most special functions served by the school social worker is that of interpretation to the school staff. Teachers with a special vested interest in the child's progress are always frustrated and sometimes are made to feel guilty and defensive by a child who does not progress. They may blame themselves or cast about for a culprit outside; often the parent is a logical candidate.

They need to realize that parents have problems too and feelings of which they are not aware. Many times the social worker's chief service is to facilitate communication among father, mother, teacher, and child.

Finally, the state of our present knowledge gives us a few ideas along the lines of prevention in which the social worker might participate. It seems to this author that opportunities of working with parents in groups have not been sufficiently exploited. Preschool parents, fathers of sons with primary learning inhibitions, mothers of nonproducing sons, parents of children of average or slow-learning ability—all offer possibilities for group work. Such ventures are particularly appropriate for the social worker in the school setting where education rather than treatment is rightfully emphasized.

Ethnocultural Identity and Mental Health

by ALFRED A. MESSER, M.D.

These observations were stimulated by my experiences in a mental health center where family groups of three generations were seen together in one room at one sitting. Interviews were both for diagnosis and for treatment. The findings to be reported concern the fact that nowadays increasing numbers of people feel more at ease and freer to talk about their ethnic and cultural backgrounds than immigrants and their offspring did a generation ago. Anxiety over being "different" has diminished. It is my belief that an awareness of these roots and their incorporation into the total identity of the individual can augur for better mental health. In other words, there is less self-consciousness now than in years past about being accepted as an "American" even though one's family name or background is obviously foreign and the family speaks a foreign language.

One problem in presenting a report such as this is to decide how best to limit its scope. How do we define "race" and "culture"? When we speak of "identity" need we include the whole concept of alienation? We all know the difficulties that can be encountered in defining "mental health." Therefore, rather than getting bogged down in definitions that can be challenged endlessly, I shall arbitrarily limit myself to describing a few phenomena that I have observed during clinical practice. The terms "ethnic" and "cultural" will have the meanings that are common currency among all of us. I shall define "identity" later.

With regard to the term "mental health," there is a growing trend toward defining the "normal" and "healthy," toward help-

ing patients maintain "homeostasis," and toward promoting "positive mental health." We have all been burdened by a carry-over from general medicine with its emphasis on pathology. A cardiologist, for example, can much more easily describe a severely damaged heart than he can talk about a normal heart. "Mental health" can be said to be a person's capacity to use his abilities, skills, and creative talents freely to his own satisfactions and within the realm of his own set of values. This is in harmony with his own realistic needs and does not interfere with the needs of his fellow man. This definition encompasses such terms as "self-realization," "self-esteem," "maturity," and "idealized image of self."

My experiences in the area of ethnocultural identity took place with a group of people who came for treatment at a mental health center in a city of 100,000. The city is fifteen miles from New York. The population is predominantly middle class with about equal numbers in the white-collar and blue-collar groups. There are a great number of first-generation Americans who still maintain contact with, and sometimes live with, their immigrant parents.

The majority of the patients were seen as members of intact family groups which might include the grandparents and close blood relatives as well as parents and children. The psychopathological disturbance within the family was often expressed by symptoms in the children. Thus, by correcting the disturbance in the family, we are treating the disorder in the child.

In using this approach I have been able to observe, in one room, immigrants, their first-generation offspring, and second-generation Americans. Here was a microcosm of interplay between the old and the new: the deeply ingrained structure of an Eastern European family, for example; the self-conscious first-generation group struggling to find a way between the Old World of their parents and the twentieth-century life of their American neighbors; and the grandchildren, who have almost completely identified with a so-called "American way of life." The latter are occasionally curious about what life in the Old World was like.

The origin of the process of Americanization is clear. The individual who is "different" has trouble gaining acceptance. Few people welcome a stranger who comes to stay. If his language and

customs and form of worship are different, he is shunned the more. The opportunities for education, jobs, housing, and club membership were, of course, most favorable for those with a built-in social status by virtue of birth; the next best opportunities went to those with the most "look-alike and sound-alike" characteristics. Thus names were changed, English was the only tongue encouraged, Old World traditions were dropped.

In some instances among minority groups who suffered discrimination, the belief was that Americanization of the children would shield them from the tyranny and persecution that their ancestors had suffered in foreign countries for centuries.

What were some of these elements that stood out during the clinical sessions, suggesting a reawakening of interest in old traditions? First and perhaps the foremost was language. There is a growing interest among first-generation people to learn the language of their parents. In the past, though the language may have been used at home, it was not acceptable because it did not fit in with the common mold. Now we find that in middle- and upper-class homes bilingual maids are sought. There is a great deal of emphasis at every educational level on learning another language besides English. It often happens that the original mother tongue of the family and the ability to speak it now become a source of pride and cohesiveness among the family group. Heretofore, it might have been used as a code for concealing secrets from the children. (The psychiatrist is often struck by the fact that although a patient may have been reared in a home in which a foreign language was spoken continuously, he is unable to understand this language. The mechanism of repression did its job.)

Then, too, the parents often encourage their elders to talk about Old World customs and beliefs. This might include a religious belief, a custom of dress, or a particular type of food. Biblical names are once more popular. Picture albums show forebears who are obviously foreign.

There are other elements which foster this interest in one's roots. Certainly travel is a factor, and I mean here more than travel merely as an expression of leisure and resources in an affluent society. The airline and steamship advertisements, Italian and

Spanish goods on sale in department stores, the daily newspaper's recipe column, and home furnishing ideas have all helped to rekindle an interest in things foreign and at the same time have given respectability and status to what was formerly a frequent source of shame. In a large metropolitan area such as New York City, it is well known that a politician who aspires to high elective office must make the "Three *I*" tour early in his campaign and receive prominent publicity. The three *I's*, of course, are Ireland, Italy, and Israel. His visits to each of these countries are attended by press coverage and picture-taking. In each country, the more native the customs he participates in, the more political benefit he may derive the following November.

Two major phenomena have abetted the process of looking toward the past and the individual's cultural heritage. One is sociologic, with the individual feeling comfortable enough in his present environment to incorporate some of the traditions of his alien family background into his identity. The second is psychodynamic, in which there is a desire to reduce anxiety and to reestablish certain emotional communication that was lost in the quest for Americanization. These will be considered in detail.[1]

In the last three decades, we have received on these shores a number of immigrant populations who, rather than refugees from famine or poverty, are primarily political escapees. They are held up as heroes to the American people. This group is far different from the group that came here in the great waves of immigration during the latter nineteenth and early twentieth centuries. It should also be remembered that new wave upon wave of immigrants, as happened from 1880 to 1921, constantly fed the anxiety of earlier arrived groups in their quest for identity as Americans.

The acceptance of ethnocultural origin as a strength reached its zenith in November, 1960, in this country when John F. Kennedy was elected President. It was not lost on anyone that his ancestor

[1] One can only speculate as to the importance of global political and economic factors in uniting peoples of different nations and background. There is the threat of nuclear war over all, and there are "free" peoples versus the "enslaved." In Central America I observed people of very different ethnic origin now united in a Common Market. These were the people who formerly constantly made war on one another. Economic strife breaks down many resistances.

Patrick Kennedy came here from County Wexford in Ireland a little over a century ago to escape one of the Irish potato famines.

Many universal elements that are passed down culturally serve to preserve the sense of family and ethnic identity. The custom of naming a child Jr. or the III is one example. When persons emigrated from some of the Central European countries, particularly from Czechoslovakia, they always took along a bit of soil which presumably was to be laid in their New World grave with them. Thus they attempted to maintain some closeness with the mother country. In the Passover feast, the participant is exhorted to place himself in the position of those people who were transported out of Egypt during the Exodus and to feel as if he were experiencing this transportation himself. In some groups it is traditional to pass on the name of a dead person to a newborn child.[2]

In the United States one can find hundreds of organizations whose function it is to preserve cultural roots and traditions and, in some instances, exclusivity. There are the Society of Mayflower Descendants, the Daughters of the American Revolution, the Sons of 1812, the United Daughters of the Confederacy, and the Baronesses of Runnymede. A newspaper man has observed that there may soon be a Society of Ellis Island Descendants.

If we look empirically at the process of identification in the human being, we find four developmental stages when there is particular concern with this. As children, we want to know who our parents are in regard to how adequately they will provide love, care, and feeding. There is no great concern as to what they do or where they came from; there is concern with the immediacy of satisfying biological needs and affectional needs. We do want stories from mother and father about their childhood, but this is

[2] This practice of perpetuating a name and an identity by passing on the name of a person can go astray. Imagine the child who is named for a grandparent who was known to be penurious and miserly; the first time this child holds back, attention will be called to the linkage of the person with his relative. I also had occasion to see a family in which a pair of twins were named by the mother—the eldest for her husband, whom she despised; the child who was born twenty minutes later, for her paramour, whom she adored. It is not difficult to understand which one of these twins fared better in life.

more in the nature of reassurance that we too will grow up to be an adult.

I am delighted to hear that some protest is being made against the practice of telling adoptive children about their origin at very tender ages. For the first several years, the child's major concern is not who his parents are, but rather whether they are meeting his needs. If they do, a positive identification is the usual result. However, we also know that there is a so-called "hostile" identification which can occur when a child incorporates an image of a parent he does not like, but with whom he feels that he must identify for safety's sake, for fear that his biological needs will not be satisfied. This phenomenon has been called "identification with the aggressor." It explains why a child will often emulate someone toward whom he feels bitter hostility.

Just prior to adolescence, there is a period where the child begins aggressively comparing his parents to those of his peers. In a word, equation is, "My father is better than yours," and ample fist fights ensue in furtherance of this sentiment.

During adolescent years there is a different type of search for identity. The adolescent looks for attributes in his family origin that he can incorporate into his own being. We are often struck with the sometimes fanatic search for ancestors that can occur during these years. In a sense, the adolescent, struggling to achieve his own identity and place in the world, seeks every support he can marshal. Erik Erikson has written in detail of this identity crisis in the adolescent. It is not infrequent that a boy or girl of this age carries around a picture of a supposedly famous or successful ancestor and indulges in frequent bragging. The youngster may also emulate this person in manner or in choice of vocation. At the furthest extreme we see the adolescent schizophrenic who claims his origin directly from God or Moses or Jesus. The failure of identity has been so complete that he can only go back to a divine being and operate entirely on a fantasy level.

A fourth type of search for identity can be seen in the mature adult. At this level, besides the curiosity as to who his forebears were and what they did, there is the more important interest in

what their character was like. The individual is no longer involved in his adolescent rebellion; he has already found himself as a person. He has been impressed by the common verbiage that someone is "a chip off the old block" or that so-and-so is the "spitting image" of his grandparent. This is, of course, the most healthy type of search in the sense that it provides a continuity of identity, something to pass on to his children, a location of the individual in terms of the whole range of time and space.

For present purposes, I suggest that we define "identity" in operational terms. Identity, then, is the answer to the question: "Who am I and where am I going?" I have rejected in the main the rigidifying concept of the Freudian mechanism of identification, that the developing child who successfully resolves his Oedipus complex then incorporates an idealized image of a parent. We know that it does not always work this way; further, it does not explain the empirical facts.

Some people do not come into their own until their thirties, forties, or even fifties. One thinks of Franklin D. Roosevelt as an example of a man who did not find his complete identity until late in life. On the other hand, when one thinks of Winston Churchill, it seems that this man has always had a strong identity of his own, going back to his dismissal from Sandhurst, where he would not conform, and to his subsequent activities as a correspondent in the Boer wars.

Further, I suggest that it is impractical to define a single identity in an individual. Rather one should think of a totality of identities: family, ethnic, cultural, religious, political, economic, educational, athletic, age, sex, body type, and so on. From this it follows that the individual sense of identity represents the integration of the group of identities. Ethnic and cultural roots are just one part of this tree.

I also feel that identity is a dynamic state and not at all a fixed or rigid quantity. For example, the car salesman who has constantly been the top seller in his agency and then falls to the bottom of the list undergoes a change of identity. Similarly, the student who wins a competitive scholarship also undergoes a dynamic change in his identity.

Some years ago, when I lived in New York City, one lady on our block, in her middle thirties, was the youngest grandmother in New York. She accosted everyone with this identity every time she spoke.

It stands to reason that where there is an integration of a series of identities, and a dynamic equilibrium, there can be an interplay between the different elements. Thus, the man who does best in his work, may do best in sexual performance; the individual with a strong family identity can withstand assaults in other areas of life more readily. In psychoanalytic work with cases of sexual impotence, for example, the analyst knows that success in other areas is necessary if one is to bring about a change toward potency. The same is true in the early phases of psychoanalysis when the patient feels himself somewhat vulnerable. He has exposed a number of his defenses and compromises. To overcome his feeling of vulnerability, he begins looking back into his family tree and tries to become aware of himself in terms of historical continuity of identity and of person. He is not just a leaf blowing in a storm.

To summarize this statement of identity from another vantage point, there is increasing evidence that the infant human being, as well as higher species of the animal kingdom, needs significant emotional contact with mothers or peer groups for later development of mating and maternal behavior. Harlow's work with monkeys is a perfect illustration of this. The memory of the actual experience is necessary.

I suggest that, in addition, the healthy adult human needs some feeling of the historical continuity of his existence. This comes about as he moves through the later developmental stages; a sense of identity has been established.

I propose use of this model in understanding the behavior of immigrants and their children. The first concern is, "Will I starve?" Many immigrants told me that the folks on the other side wanted primarily to know how much money was in the pay envelope and how many chickens were in the pot last week. The aggressive stage is typified by the battles between immigrant groups in which they often degrade each other in order to claim superiority. Only in the last two phases described above is there concern primarily with

merging the old culture with the new. Success in the end would be identity as an American without anxiety as to origin.

For many immigrant families and their first-generation children the process of becoming Americanized and of not deviating from the common norm was of the utmost importance. Any idea of incorporating the identity of the forebears was discouraged by the pressures attendant on securing the primary goal. The major trend was not to deviate from the general group. In a sense, there was an ethnic identity crisis.

From the viewpoint of a psychiatrist, perhaps the predominant motivation in looking back at one's roots is to find a means of emotional communication, both in contact between people and in teaching the offspring an emotional language. In the struggle for acceptance as Americans, many of the immigrants, as well as their first-born children, repressed much of the freeness that went along with their identity of origin. As part of this struggle, the art of emotional communication was lost. I once attended a wedding reception where the couple were second-generation descendants of Russian immigrants. When the traditional Russian *kazatzka* was played, only immigrant grandparents danced. Then, slowly, a few of the first generation ventured onto the floor, but no second-generation children joined in. The simple reason was that they had never been taught. This dance somehow represents Old World native expression, and therefore much emphasis on this in the American home would immediately stigmatize the parents as not being modern or properly involved in their new environment. Later in the course of the reception, the twist was played; I need not describe the scene.

A clinical fragment from psychoanalysis of a patient is pertinent here. The patient was a twenty-six-year-old married woman who became depressed after the birth of her first child, a boy. She was referred for treatment by the child's pediatrician. The patient was born in the Mid-West. She met her husband when they were both studying at a large Eastern university. She gave up a career as a copy writer when she first became pregnant. She described her family as typically Mid-Western, active churchgoers, and interested in the affairs of the community. Her father was an insurance sales-

man who spent a great deal of time out of the house nights and week ends. She recalled her mother as a fine hostess who entertained a great deal. Her parents were second-generation Americans of mainly Italian descent. She was the youngest of three children, the oldest being a boy and the middle child a girl. The patient spent very little time at the beginning of analysis talking about her baby and her depression, but focused more on her past. During her third week of analysis she had the following dream: "The setting of the dream seemed to be in Spain because I remember bright colors. There were a group of people around, some of whom had large hats. They were busy talking, there was some dancing, they just seemed to be having a good time together. I tried to join them but somehow couldn't. I woke up mad."

The patient's associations to the dream went immediately to the fact that she had learned of the great numbers of Scandinavians who go to the south of Spain for vacation. She had been told that the visitors are enraptured by the emotionality of the Spaniards, which she felt was similar to that of Italians. This opened up the hunger of the patient for emotional contact. She went on to complain that in her family there was little time for tender sentimentality. Her father was a "good" man but a disciplinarian "who was a fine sergeant in the Army." For him, as with most of the men in the patient's life, the display of great emotion or tears was equated with weakness, not capacity for feeling. Her husband felt as her father did.

Another issue in the broad area of mental health is related to teaching children something about their present and future roles. We are all aware of the confusion in this area and have seen the results of it. For example, one can examine the matter of teaching the young female child about femininity and her role as a woman. In the past, when life was more family-oriented, and less community- and peer-oriented, the mother taught her young daughter about sewing, grooming, cookery, and so forth. There was an attempt consciously to prepare the child for her later role in life. The same was true with a young boy. Nowadays this type of information is often left to be taught by peer groups, by young people's clubs, by the school, and is even imparted by television

commercials. The young girl's learning in this area is haphazard. I have heard many mothers of teen-age girls confess that they wish they had the opportunity to raise their daughters over again. If this were the case, they would start when the child was six and teach her "how to be a woman."

In terms of emotional language, also, the European woman was taught that she must never attack a man in the area of his sexual potency. She could accuse him of being lazy or shiftless or of drinking too much, question his fidelity, but never attack his sexual performance. Even if this were a problem in a relationship or marriage, the woman always inhibited direct expression of criticism. Similarly, a man never attacked a woman in terms of her femininity. He might scold her for being wasteful of money or for being a terrible cook, but never belittle her sexual charms. How different this is from the practice in some segments of contemporary American society. A prize-winning play, *Who's Afraid of Virginia Woolf?*, certainly gives a different picture, one which we have all seen reflected clinically.

In the family group there is often a shared identity. The family has certain problems in common. All the members share these, and various roles are taken by family members to aid all in dealing with a common problem.

It is doubtful that there can be an ethnic identity without a prior family identity. There are the Horatio Algers, but these are few and far between. Failure in the family identity is often reflected in the resort to pathological isolation, extreme dependency or religiosity, marked deviation from the norm of the group. Sometimes in his anxiety an individual will fake a whole family tree going back to the American Revolution. Any psychiatrist has seen a number of these individuals and knows the price they pay whenever there is a friendly discussion of family ancestry.

The opposite of failure in family identity can be found in the Chinese family. In any large city with a substantial Chinese population one can see the family clubs, often with their own buildings, whose membership is comprised of the extended family, frequently running into the hundreds. Much has been written about the low delinquency rate among the Chinese. (Another factor which may

have abetted this tradition is that in America it is difficult for an Oriental, unlike members of other immigrant groups, to hide his identity, because of facial characteristics.)

The discomfort of some people in the helping professions in regard to an emphasis on cultural identity is typified in the following anecdote. One prominent New York psychoanalyst assured me that his only concern about religious or ethnically oriented holidays was that his patients insisted on taking off from analytical sessions on those days. He was constantly in a struggle as to whether or not he should charge them for missed hours.

There has been much said recently about the matter of conformity. Presumably, one of the sicknesses in our society has been an anxiety that causes people to seek security for conforming to a set image or to a standard that is alien to their own personal desires. Similarly, one should consider why some people insist on conformity in all of those around them.

It stands to reason that with a healthy identity, that is, a sense of individual identity, the whole matter falls into its proper perspective. The individual who has "found himself" does not, as the term is used, need to conform. He is free to make his own choice. Nor does he have to run to a beatnik existence or take up beachcombing to be a nonconformist. Actually, these reactions turn out to be conformity of another sort.

In the 1920s and 1930s the social psychologists made much of the fact that the immigrant and his children who still identified themselves as members of a cultural or ethnic group considered "foreign" could only experience anxiety in terms of their identity as Americans. Thus Poles in America, Germans in America, Jews in America, Italians in America, and so on, who had not resolved their identity as either Poles or Americans, as Italians or Americans, would continually be subject to anxiety from both within and without whenever this question was stimulated by an event of dishonor that involved a member of their minority.

This is needless anxiety, and it is a needless position. Incorporation of the ethnic and cultural factors into the functioning identity of the individual here and now diminishes what anxiety there is and insulates the individual against further anxiety. A comfortable

feeling about one's origin, and an appreciation of its individual and distinctive cultural characteristics, is indicative of, and/or essential to, good mental health.

This system works in the other direction also. If there is no cleavage in identity between ethnocultural root and status as an American, there is a better social health as a nation. The need for withdrawal into tight little groups to preserve old ways becomes unnecessary. The overcompensated individual whose life is dedicated to being a "professional" member of a minority group falls by the wayside.

On the opposite side of this coin, the small units within minority groups themselves whose goal it is to disinfect any ethnic sentiment that might sound foreign, and thus un-American, would vanish.

Studies of prejudice have shown that the individual who is the victim of prejudice often brings this upon himself, consciously or unconsciously, by disturbing the desired image of a particular family or cultural group. Thus the immigrant or his child set about very quickly to become completely "Americanized." Those of his group who still retained the Old World customs, and thus disturbed this sought-after image of being no different from long-descended Americans, brought the victim much prejudicial attack. Similarly, it aroused a great deal of anxiety in a cultural group because of their striving to become a part of the mass. Remember the furor over *The Untouchables?* Or that which attends an announcement of a production of *The Merchant of Venice?* Dialect comedians are a fast-vanishing breed.

The point is, if one can accept the Einsteins and the Enrico Fermis, why should the Mickey Cohens and Al Capones stir so much anxiety over identity? There is both good and bad in everyone's background.

Since the foregoing was originally written, I have moved from New York to Atlanta, Georgia, which, of course, is a completely different laboratory for the study of ethnic and cultural identity. In Atlanta I have seen a number of white persons of middle- and upper-class background who have come to me about analysis. Often these persons were brought up in homes where child-rearing was left mainly in the hands of the classical Negro mammy. She

was the primary source of the infant's care and feeding, warmth and love; she provided the balm for his childish hurts. She was his link with life. Later on, because of social pressures, this link had to be broken, particularly any outward manifestations of emotion and sentiment. The paradox which follows from this is obvious when one thinks in terms of the earliest identification in the child.

There is a movement now afoot among certain Negro groups to rekindle an identification of American Negroes with the emerging peoples of black Africa. This movement has made itself felt in high places in the United States Government. Presumably, there are aspirations which both groups have in common, and thus an identity could be linked in terms of these drives. The parallel might be the relationship of the Irish-Americans to Ireland, or Zionist-Americans to the state of Israel. (In a curious way, the Negro may be viewed as an immigrant. This, then, is an unconscious attempt to provide a historical continuity of identity.)

It is my feeling that this movement is doomed to failure. First of all, there is a hiatus of many generations between the original Africans who came here as slaves and present-day American Negroes. There has been little contact between the two until recently. The black African's identification is primarily with his tribe, whereas the Negro American's identification has tended more toward individualism. There has been a concomitant attempt of middle-class and upper-class Negroes to incorporate the values of the white man. These are the only values they can aspire to in this culture since their own were forcibly eradicated hundreds of years ago and are unfamiliar to them. Along with dress and speech, American Negroes have adopted the white man's religion. Evidence of the dissimilarity between African and American Negroes can be obtained on a university campus, when one talks with African students. The African student feels completely apart from the American Negro except that they are subject to the same prejudices and the same discrimination here. Other than this, there seems to be little ethnic or common social bond that can be uncovered. The African usually considers himself the superior of the two—he is a man with a country.

These factors may be of some importance in understanding the

Black Muslim movement in the United States. There can be no doubt about its growth. It appeals to those who are searching for militancy and active protest to overcome their suppressed frustration and resentment; however, in the deepest sense it appeals to something that is inherently Negro, not something borrowed from a white culture. Further, it preaches that this is endowed with superiority and is not secondhand. In the model proposed above for the study of identity, this is the second, or aggressive stage. But where to from this point? It is something to think about.

Emerging Patterns in Community Planning

by ROBERT MORRIS and MARTIN REIN

THE FIELD OF COMMUNITY ORGANIZATION and community welfare planning is experiencing a renaissance of activity characterized by new ideas, questionings, criticisms, and mechanisms. An assessment of our theoretical framework for planning in social welfare is long overdue, and voices seeking it are heard with increasing persistence. The purpose here is to highlight some of the factors that account for this ferment and to identify the dilemmas and choices associated with a period of transition. The strategy of this attempt rests on the conviction that a theoretical framework must come as close as possible to describing social reality, and must strive to reduce the complexity of the problem by examining limited but focal aspects of planned change.

Present welfare planning structures and ways of thinking about welfare planning have been historically conditioned. Community organization emerged from a complex of voluntary social welfare organizations whose primary commitment was to assist the individual in coping with his social reality. Their chief, although not exclusive, preference was to work with "the infected individual rather than to eliminate the infection from the environment." [1] Welfare planning was therefore based upon this approach to social problems. In addition, the voluntary agencies were reluctant to have government sponsor welfare services. This concern found expression in their preoccupation with the reduction of pauperism (the

[1] Barbara Wooton, *Social Science and Social Pathology* (New York: Macmillan, 1959), p. 329. Note that this preference refers to the early agencies of social work in the United States, not to the later emerging professional organizations.

receipt of financial aid from governmental sources). It will be recalled that the Charity Organization Society bitterly opposed public pension schemes for widows and children lest such programs might come to be regarded as a right; and it favored a voluntary program designed to work with individuals.

In urban centers, where our planning structures flourish, an extraordinarily complex variety of organizations has developed over the decades to form the matrix for planning, with their irrationalities, contradictions, and overlappings providing the impetus for action.

In this scheme the importance of a local community deserves special comment. Voluntary agency planning flourished in the belief that local communities constitute the essential foundation of American society—local communities which are reasonably stable and capable of being comprehended in their entirety by the citizens residing in them. Out of this view emerged welfare's concept of the total community.

This commitment to the locality was accompanied by conviction that local destinies could be locally controlled. National and nonlocal influences were certainly recognized, but they were considered secondary and controllable by local forces.

This local commitment required reconciliation between the realities of select leadership and the aspirations of democratic participation. Thus, welfare services and planning became recognizably controlled by an essentially elite leadership in each community, consisting at first of those well-established personalities who had developed over the years a sense of civic obligation and, appropriate for their time and background, a comprehensive view of their communities. Associated with the socially elite were an economic elite, often combined in the same families. Economic power in the nineteenth century was believed to be vested in local industry, under local control. These economic sinews became the foundation for the support of much of social welfare. It was only later recognized that this elite leadership was primarily white and Protestant, representing the early social stratification of American society.[2]

[2] Paul A. Miller *et al.*, *Community Health Action: a Study of Community Contrast* (East Lansing, Mich.: Michigan State College Press, 1953).

The leading citizens who controlled welfare nevertheless sought to make room for a widening democratic participation in the hope that other citizens would acquire the same values and the same broad, comprehensive view of the community. Differences of opinion and point of view were certainly recognized, but it was assumed that these differences would be overcome or resolved as more citizens acquired views not unlike those of their leaders. While in retrospect we can recognize that this total community view tended to reflect the dominant culture of the times, that is, the white Protestant ethic of community leadership, that in no sense reduces the significance of this comprehensive aspiration.

Lest this schematic summation of historical origin seem too pat, regional differences can be early identified. Patterns of welfare planning varies discernibly as one moved from the Northeast sector of the country to the West and to the South.[3]

Others factors have contributed to the development of our present ways of thinking about welfare planning, and as a result of this past, our current thinking about planning is controlled by four aspects: a belief in a federated structure; a confidence in a rational utopia; a goal of reallocating, rearranging, or coordinating existing resources; and a professional strategy of consensus seeking.

1. *The dominant characteristic of our welfare planning is its federated character as typified by local welfare planning councils.*

Federation aims at representation of autonomous groups, hence it has responsibility but limited authority. Various subgroups are brought into cooperative participation through representatives, although not all groups in community life are necessarily represented, nor do all groups have equal power and influence. This structure serves as an arena in which change is discussed and argued by the various subgroups represented, but the federated structure itself remains primarily neutral. The structure is circumscribed by the interests of the groups that have assembled within its fold. The strength of the federation is dependent upon the willingness of constituent groups to relinquish their autonomy on occasion. The functioning of this structure is best characterized

[3] Sanford Kravitz, "Sources of Leadership Input for Social Welfare Planning" (unpublished doctoral dissertation, Brandeis University, 1963).

as a commitment to one view of democratic participation and is reflected in such statements as, "to help diverse interests, recognize and respect difference, resolve conflict and achieve mutually satisfying community goals." [4]

Consistent with this view is the belief that the federated body can best serve as a neutral ground from which contending positions can be aired and as a battleground on which members can find ways of meeting the crises which they mutually experience. Such a structural commitment leads inevitably to an avoidance of conflict whenever possible and the seeking of action in the name of the "total community" only where overwhelming consensus can be secured from constituent members of the federation.[5]

These qualities of elitism and the shunning of controversy have been described by a trustee of a federated organization:

> Voluntary welfare administration is—and has been—essentially a gentleman's avocation. People who offer their experience and services to this work are generally from social, intellectual, and income levels well above the average. They have social consciences. They want to do something about conditions in the world around them. And they do. But, by nature, they are not inclined to take unpopular positions about things. They tend to work through reasonableness, thoughtful discussion and compromise. Controversy, in general, is avoided. Playing it safe is sometimes the preferable strategy when key community issues come up.[6]

2. *Federated structure is the organized expression of a belief in rational utopianism.*

Much available community organization theory is utopian in that not only are its goals based on values, but the precepts designed to guide actions are also based upon these same values. The consequence is that guides for action are formulated from a theory of what the world ought to be and proceed as if the world *is* what it ought to be. Manser says that "we believe that communities as

[4] Violet M. Sieder, "Current Developments and Problems in Changing American Communities—an Over-all View of Community Organization," Workshop on Community Organization and Community Development, Brandeis University, 1960.

[5] Robert Morris, "Basic Factors in Planning for the Coordination of Health Services," Part I, *American Journal of Public Health,* LIII (1963), 248–59; Part II, *ibid.,* pp. 462–72.

[6] Harry T. Seeley, "The Challenge of Social Change to Community Welfare Councils," Citizens Conference on Community Planning, Indianapolis, 1963.

aggregations of individuals possess inherent capacity to change—to choose wisely in the management of their affairs, and the right and responsibility to determine how best to serve the health and welfare needs of their citizens." [7] Murray Ross, the most articulate spokesman of this emphasis on the interchangeability of ends and means, refers to the process of "community integration" wherein the primary goal of community organization is to advance the democratic process and strengthen a community's members' capacity to work together.[8] Thus the means become the end.

The existing philosophy for planning is furthermore utopian in that it equates services with goodness. The provision of more and more adequate services to meet a social problem is usually considered a social good, while decrease in services is considered to be a social evil. Social agencies are seen as primarily needs-meeting institutions. While this construction is sound, it frequently, and perhaps unintentionally, fails to take into consideration the agency as a social system which reflects the interest of diverse supporting community subgroups. Thus agencies must survive in the environment which supports them, and frequently their survival and growth dominate in decisions about action alternatives. The fact that agencies can become ends in themselves, have power in their own right, and can become instruments of vested interests is often overlooked. When this tendency is recognized it is viewed in a moral light and not as a normal phenomenon of human social organization which requires appropriate theory as to handling.

Finally, community organization theory is utopian in that it sees a community as essentially unstratified and not representative of various and often conflicting subgroups. The inherent good nature of man should enable him to act in good faith for the good of the total community when certain good impulses are liberated in him. Conflicts in vested interest as integral facets of the relationship between man and his environment are largely omitted in this view.

Current theory is rational as well as utopian in that it is based upon a conviction that if communities have enough knowledge,

[7] Gordon Manser, "A Critical Look at Community Planning," *Social Work,* V, No. ■ (1960), 35.

[8] Murray Ross, *Community Organization: Theory and Principles* (New York: Harper and Brothers, Inc., 1955).

have gathered enough facts, and are forcefully confronted with certain problems, they will act appropriately to solve them. Ignorance and faulty communication are considered to be prime obstacles to desirable action. "Once the violations of this doctrine became inescapably visible to everyone, community members felt obligated to take action against the discrimination in their midst and the moral position of those who openly defended the discrimination became clearly untenable." [9]

This view further assumes not only that knowledge will lead to action, but also that it will lead to rational action. A given set of facts can lead to only one logical conclusion, and this conclusion will be accepted by decision-makers and others in positions of influence once they understand the underlying facts. Alternatives for action which do not stem from such a single-track rational process are seldom taken into account—methods of negotiation, bargaining, and coalition are seldom stressed.

3. *Federated bodies in the past have devoted most of their energies to problems which grew out of distribution and redistribution of resources among agencies, clients, personnel functions, and funds.*

Other forms of change and community action have been acknowledged as desirable by federated bodies, but all frank examinations of their operations have concluded that a predominance of their energy has been directed to this redistributive or coordinative function. The federated agency is primarily concerned with the network of health and welfare agencies which constitute its domain. This network consists mainly of direct-service agencies, with the various components interdependent upon each other; their shifts in the goals or operations of any one agency will affect the capacity of others to achieve their ends.[10] For example, if a child-care agency ceases to be a legally protecting organization and becomes a therapeutic agency, this immediately affects the demands made upon other community services and an accommodation must

[9] Ronald Lippitt, Jeanne Watson, and Bruce Westley, *The Dynamics of Planned Change* (New York: Harcourt, Brace and World, Inc., 1958), p. 45.

[10] Sol Levine and Paul E. White, "Exchange as a Conceptual Framework for the Study of Interorganizational Relationships," *Administrative Science Quarterly*, V (1961), 583–601.

be arranged.[11] Similarly, the distribution of resources is affected by whether these resources are in a state of equilibrium, expansion, or contraction. Thus, when financial resources are primarily derived from voluntary philanthropy and these funds are increasing in volume, certain types of coordination may take place; when funds from the same source are restricted or contracting, other consequences result, and become the chief interest of the coordinating agency.

While planning is essentially coordinative, change efforts are attempted, but they are largely initiated because of crises and disequilibria in the resource bases of agencies (such as a drop in united fund income) or because of overwhelming, uncontrollable demands upon stable resources (caused, perhaps, by a sharp rise in unemployment). Because of the origin of these federated bodies the changes they attempt to make in response to crisis seldom involve basic alterations in the conditions of the surrounding society which may be responsible for the crisis. Instead, the federated body concentrates necessarily upon changes within its own network of welfare agencies. At one extreme are mergers in the interest of efficiency. At the other extreme are efforts to coordinate activities in instances where the autonomy of agencies is largely unaffected. Further changes may, over a substantial period of time, lead to the emergence of new resources and new services, but these seldom involve an attack upon the causes of social problems in the society.

Thus federated bodies are able, in the main, to focus upon a limited band of problems that are important to the types of agencies which have been brought together in federation. Whether such bodies have, in fact, dealt more substantively with changes going beyond this limited arena remains for further study and proof.

4. *The strategy of choice developed out of this past history has been one of consensus seeking.*

Community planning, education, and practice have concentrated upon those techniques which will help divergent interest

[11] Martin Rein and Robert Weiss, "An Analysis of the Network of Community Agencies Providing Child Protective Services in Massachusetts" (Brandeis University, 1962; mimeographed).

groups to search for a common denominator for joint action. Since the viability of the federated body depends upon almost complete agreement, the dissenting organization carries a degree of influence disproportionate to its contribution to the solution of the social problem with which it deals. Thus it becomes clear that decisions frequently must be reached through informal channels so that the federation is not divided into factions by premature and divisive action. Formal voting oftentimes is simply the expression of a general consensus previously reached. Chairmanship is developed to a fine art to avoid calling an issue to a vote unless there are clear indications of widespread preagreement. Similarly, goals are frequently couched in broad and ambiguous terms to avoid a concentration of conflict. Proper decisions for action are those which avoid resentment of major participants in the federation and sustain the stable affiliation of many subgroups.

These four basic characteristics which emerged from the historical antecedents described above served that history in many significant ways. A stable community with a comprehensive community view necessarily requires a mechanism for assembling diverse interests in order to assure their loyalty and a set of procedures and strategies directed primarily to achieving the comprehensiveness of view and the rationalization of resources which its over-all pattern requires.

The situation in which planning today takes place is materially different from that we have described. American communities and American life are no longer stable, nor is there any substantial indication that stability will be either desirable or achievable in the foreseeable future. Instead, we are experiencing an unprecedented explosion in population and an extraordinary mobility of people back and forth across the face of the nation as economic, political, and social waves of the mid-twentieth century require. Only 5 percent of our people die in the community of their birth. Thus southern California, the Southwest, and the South are expanding by an increment of a thousand families a day, while other parts of the country are losing population at an equally rapid rate. The great exodus of Negro families from the South to the North constitutes one of the great migrations in all history and has changed

the character of our urban centers. Annually, one in four American families makes a major move of residence. Not only are new communities growing, but old ones are either expanding or contracting so rapidly that stability can hardly be expected. More significantly, a flow of population means that the goal of an encompassing comprehensive view of any community is both difficult to achieve and certainly difficult to extend to masses of the population in any generation.

The economic character of American communities has changed. Today, with only a few exceptions, industries which exert a great economic influence on community life are locally sited but nonlocally controlled. Moreover, they are administered by a new managerial class which, in turn, is extraordinarily mobile. One of the substantial foundations for welfare control and policy-making is thus removed from the local community to regional or national centers.

There has further been the remarkable growth of public health and welfare organizations with a preponderant responsibility for services, both as regards the numbers of people served and the volume of funds expended. While voluntary associations remain vigorous, they are no longer paramount. These public programs are to a large extent sustained and generated by nonlocal resources derived from Federal and, to a lesser extent, state levels of public authority. Another essential for welfare planning is thus located outside the local community, representing a major shift in the conception of the community to be served by welfare planning structures.

Minority groups have assumed a new position of influence in our urban centers (and since welfare planning has flourished in urban centers, these people become our major interest); for in most urban areas nonwhites constitute 25 to 30 percent of the population. This proportion is likely to grow, and these groups are already grossly underrepresented in our health and welfare planning structures.[12]

As a result of these four changes, our community life has become

[12] The NAACP bitterly attacked the Philadelphia Council for Community Advancement, a new community welfare planning organization financed by the Ford Foundation and the President's Committee on Juvenile Delinquency, for its failure to include sufficient Negroes in key leadership positions. Such disputes are now commonplace.

infinitely more complex than the one out of which our present welfare thinking was derived. More than 75 percent of our people reside in metropolitan areas in the new megalopolis. Many autonomous, strongly organized special interest groups live side by side, but independently and uncontrolled, either in the core city or in its suburbs. These groups are rooted in the primary forces of modern industrial life. National economic interests, ethnic groups, trade unions, and others are now added to the traditional voluntary and essentially elite sectarian and religiously rooted welfare influences of the past. There is as yet no sure indication that these powerful basic influences can be brought together intimately in a voluntary structure, although they are contained effectively by our basic governmental and political processes of local, state, and national government.

The new community is full of strife, conflict, uncertainty, and anxiety. At the same time, there can be discerned the recurrent strain of many quite old-fashioned problems. Juvenile delinquency, poverty, dependency, family disorganization, poor housing, disease, and mental illness are all still with us. However, their origin, their scope, and their understanding have all been substantially altered. There is wider acceptance of the view that the etiology of many social problems is rooted as much in social conditions as in the individual. Many would argue that social conditions are a fundamental cause, and even those who are committed to individual adjustment to the environment recognize that the unhealthy environment must be treated as much as the ill individual.[13]

The great scientific and technical achievements of the twentieth century altered the character but have not significantly reduced the prevalence of physical and mental ill-health, delinquency, poverty, poor housing, and the other social problems with which we have always been concerned. Even if there has been no increase in the incidence of these social difficulties, their firm persistence has been disturbing. We have attempted to deal with them by *ad*

[13] Richard A. Cloward, "Social Problems, Social Definitions and Social Opportunities," prepared for the Regional Institute on Juvenile Delinquency and Social Forces, 1963.

hoc legislation; by the development of extensive public welfare programs; by an elaboration of therapeutic skills directed to the individual. None of these developments seems to have made sufficiently deep inroads to satisfy either social workers, health workers, or the citizens. The result has been a renewed search for ways of dealing more effectively with these problems.

The ferment has not been solely one of intellectual and scientific pursuit. The impetus to develop new specialized service organizations is a well-known phenomenon. The growth of specialized health agencies since the Second World War is too well known to require elaboration.

The discovery that social problems persist has troubled us because we had been lulled into complacency by welfare expansion and by overconfidence in the tempo of our great technical achievements. Advances in the medical sciences have only brought us to a confrontation of even more intractable chronic diseases for which we have no medical solution and for which we need a combination of social and medical approaches. Appropriate care of the large volume of long-term illness requires a great expansion of manpower and of physical resources. Important discoveries in psychiatry have not noticeably diminished the incidence of mental illness, although they have permitted us to consider new methods of treatment. Unfortunately, the treatment of mental illness outside institutional walls encounters the gross hazards provided by the new environment just described. The handling of delinquency and all forms of antisocial deviant behavior, such as illegitimacy, drug addiction, and so on, must be dealt with in a community in which multiple standards exist side by side without synthesis or apparent coherence. Poor housing cannot be resolved solely by the construction of new buildings because these new structures must somehow be related to the racial relationships which characterize our urban centers. Solutions through public assistance and vast public programs are not sufficient in themselves because they fail to take into account the enlarged aspirations of diverse social and economic groups, the raised plateau of expectation about what is a minimum standard for social existence.

These problems, or the new understanding about the dimen-

sions of old problems, along with the new centers of influence in community life, have not been adequately articulated with the previously developed welfare planning structures for health and welfare. As a result, old planning structures have been increasingly criticized, and both new structures and new approaches to welfare planning are increasingly being experimented with.

The new forms for planning and the new planning practices can be reviewed by comparison with the federated structure, the rational utopian view, the goal of coordination, and the strategy of consensus which characterized our past.

These new forms can also be understood in light of the changed community circumstances which we have just been discussing. If our past history led naturally and logically to the development of a certain approach to planning, it may be equally true that the new community life will lead equally to its own appropriate forms of planning.

What are these new approaches to planning? They are the new urban planning agencies, the mobilizations for youth, the community mental health centers, the public health department, the new rehabilitation concepts in public welfare. A comparison between these approaches and those of the traditional community-wide welfare planning council has been blurred because each of them uses the term "comprehensive community planning" with equal ease.

In some fifteen or twenty major cities urban renewal planning has stimulated the development of new organizations committed to the human and social aspects of urban renewal. These organizations are rooted in the necessities for the actual rebuilding of our core cities. They are equally committed to a comprehensive view of the needs of the human beings who are affected by this renewal. As a result, they turn to the schools, the family welfare agencies, the settlement houses, the hospitals, and seek to engage all of them in program development directly associated with the problems of family relocation and physical rebuilding.

Community mental health centers are committed to the development of positive mental health and adequate care of the mentally ill. They seek to encompass in this effort our schools, our family

welfare agencies, our settlement houses, our general hospitals and our mental hospitals. In similar fashion, our youth development efforts, best characterized by Mobilization for Youth in New York City, are concerned with juvenile delinquency and the lack of opportunity for deprived youth. They seek to involve the school system, family welfare agencies, public welfare agencies, settlement houses, industry, and labor unions in the problems of youth opportunity as a major attack on delinquency.

Public welfare agencies are attacking the problem of dependency with a broadened concept of rehabilitation. They seek to engage the interest of schools, family welfare agencies, settlement houses, rehabilitation centers, hospitals, and industry with the view to overcoming the conditions which lead to dependency and opening up opportunities for families now on public assistance.

What we see is that a number of key social problems—mental and physical illness, deviant behavior or delinquency, financial dependency, and poor housing—are each viewed as a central organizing theme for comprehensive community planning. Each subject identifies a community of agencies and interests demanding its own action. Each grouping has the character of a community and each of them is approaching the same resources for its purposes.

This proliferation of planning centers has been decried and has met with harsh criticism on the grounds that it destroys the essential unity of comprehensive community planning. What critics of this evolution have not taken into account is the generating source for these multiple developments, namely, the changed community. The stable community has been replaced by a community of great complexity with many special interests. Each of these special interests is sufficiently complex in itself to justify a perception of itself as a community with many subelements. The fact that these specialized communities are paralleled by other specialized communities is a matter of no great concern to any of them because the requirements of their own community demand all their energies. Thus one interpretation would be that the total community concept has been paralleled by, if not eclipsed by, the rise of multiple special communities. These new welfare planning ap-

proaches are characterized by the following elements: they are partisan rather than federated; their influences are derived from nonlocal rather than local sources; they are likely to be public rather than voluntary; they are concerned with political skills more than they are with consensus-forming skills; and their goal is change in the community structure rather than coordination of available resources.

The new planning structures are essentially partisan in character. Their policy-making leadership consists primarily of like-minded persons with a definite image of the change they seek to promote and the objectives toward which they are striving. They seek to modify their environment so that it becomes consistent with their aims and objectives. Cooperation is desired, but primarily around their focal concerns. This contrasts with the federated approach in which the federated planning organization seldom if ever seeks to impose its image upon its cooperating organizations.

The base for much of the specialized interest planning is found outside the local community. The origin of stimulation of ideas is mainly located outside the local community—in the Ford Foundation, the national health agencies, the Federal Urban Renewal Program, the President's Committee on Juvenile Delinquency and Youth Crime, and the Hill-Burton Hospital Construction Program, to mention but a few. At the same time, funds are gathered (from local citizens, it is true) at national centers, especially through taxation, and redirected into local communities through national channels, such as the U.S. Department of Health, Education, and Welfare, the Housing and Home Finance Agency, and others. These channels are often fixed by congressional action which governs the funding of new programs.

The magnitude of change envisioned by some of the new planning organizations is so great that it has not yet been grasped by voluntary welfare agencies. As a result, public and governmental structures are either the centers for this planning or they become the dominant partners. Public health departments or state rehabilitation commissions are likely to be the generating source of planning in the field of physical health; state departments of mental hygiene, community health clinics, and community mental

health boards, in the field of mental health; the Department of Public Welfare, in the field of dependency; the mayor's office or an urban renewal agency or department of public housing, in urban renewal.

Where the initiative is not vested chiefly in public programs, new organizations are created which bring public and voluntary organizations together into a new alignment, illustrated by agencies established to deal with the social consequence of urban renewal—Action for Community Development, in Boston; Community Progress, Inc., in New Haven; Philadelphia's Council for Community Advancement. Public organizations and city government are likely to be the principal partners in these new organizations. Thus the redevelopment authority, the schools, and the health or mental health departments enlarge their functions and assume responsibilities for community-wide planning (albeit along the axis of their special interest) previously considered the domain of the comprehensive voluntary welfare council.

The goals of the new planning organizations can also be contrasted with those of past planning bodies. They are concerned with new ways in which to alter the environment out of which social problems emerge. They are thus engaged in the pursuit of defined objectives, the achievement of which can be measured. They are less satisfied with coordination of available resources and seek in some more fundamental fashion to change the conditions which give rise to these problems. They seek to develop and enlarge rather than to integrate. Thus the problems of delinquency are attacked through the schools and employers. The schools provide a base for reaching all youth and their function is enlarged to provide, not only minimum education, but also appropriate educational facilities for all youth commensurate with the requirements of the society into which they are going to move. The schools may even become centers for much broadened character-building activities since they are more widely based than that of the smaller units of settlement houses.

The approach is not primarily one of motivating youth to desire a better life (an approach based upon the assumption that the problem rests within the individual), but rather one of opening up

jobs in industry, on the assumption that the problem lies in the character of economic opportunity available. In the field of mental health, the community clinics are not exclusively concerned with assisting mentally ill individuals to adapt to the harsh realities of a competitive world; they turn to the development of supporting attitudes on the part of large segments of the community or to a major improvement in community receptivity of the mentally ill or handicapped. As part of the planning stimulated by the U.S. Department of Health, Education, and Welfare, the Federal Government is now employing workers who have a history of mental illness, a significant departure from previous policies.

In the health field there is no longer satisfaction with motivating individual patients to seek medical care through health education. Attention is now being directed to the organization of medical care to assure comprehensive and continuing health services. Many of the deficiencies in our health picture are viewed as inherent in the way in which we have organized the use of physicians, social workers, nurses, and so on, rather than as due to lack of information on the part of patients, necessitating devices to motivate potential consumers to use health services. The current assumption calls for unification of home care services, expansion of social insurances and group practices, and development of inclusive outpatient services; the former assumption demanding guidance, therapy, and education of the individual.

As is common with any form of social innovation, new problems are encountered as we seek to resolve old ones. It is perhaps readily evident that in the new situation, unclear and changing as it is, two problems can now be identified. The several planning approaches, each organized around a special interest, are necessarily in competition for limited funds and personnel. There is no definite allocation of funds and other resources for a balanced plan of action.

There is also in any community competition for the interest and help of citizens. The mental health organizations, the health agencies, the youth organizations, the urban renewal groups, are all endeavoring to attract the wholehearted interest of supporting citizens. The schools seek to develop parent-teachers associations

with enlarged responsibilities; urban renewal agencies want to develop local block organizations; welfare councils try to organize neighborhood planning councils; settlement houses encourage the formation of tenant groups. In the abstract, it would appear that each of these organizations is appealing to the same citizen reservoir. In fact, they may be appealing to different citizen constituencies, but this remains to be determined by further analysis and study. It is not yet clear whether the central pool of community leadership with a comprehensive community view survives today and is the object of search by each of these special interest planning groups; or whether there are fragmented leadership centers, each attracted to one of the special groups mentioned above.

The present situation is still too new and too fluid to permit any final conclusions. However, one trite issue is clearly presented. Shall we strive for a new reintegration of these multiple planning centers into a comprehensive community planning organization consistent with our past tradition? Or shall we accept the existence over an indefinite period of time of multiple planning centers which must be in parallel competition? The first approach has been forecast by Zimbalist and Pippert; [14] the second has been developed most lucidly by Banfield and Dahl.[15]

Since our communities are now not only more complex, but also include a greater diversity of powerful influences and special interests, the question may reasonably be asked whether a reintegration into comprehensive community approaches can take place at any level other than government—or within government at any level other than regional, state, or Federal. If we seriously believe that reintegration can take place within the voluntary concepts of the past, we need to visualize a voluntary association capable of embracing the powerful economic, ethnic, and sectarian interests which dominate in our urban centers. It is unclear whether any community can delegate so much authority and influence to any voluntary organization based upon past patterns. If this is to be the

[14] Sidney E. Zimbalist and Walter W. Pippert, "The New Level of Integration in Community Welfare Services," *Social Work*, V, No. 2 (1960), 29–34.

[15] Edward C. Banfield, *Political Influence* (New York: Free Press of Glencoe, 1961); Robert A. Dahl and C. E. Lindblum, *Politics, Economics and Welfare* (New York: Harper and Brothers, 1957).

route followed, new voluntary structures not now envisioned will have to be fashioned.

This position is not widely promoted today. Commenting on the exhaustion of nineteenth-century ideology by 1950, Bell observes that "few 'classic' liberals insist that the state should play no role in the economy, and few serious conservatives, at least in England and on the continent, believe that the welfare state is 'the road to serfdom.' " [16]

If the development of such potentially reintegrative planning is to center within our basic democratic governmental framework, we are also confronted with new and complex problems. Social problems will not defer to existing political boundaries. The need for regional planning and for embracing larger and larger units of government presents us with an ideological dilemma. Social workers favor self-determination and the control by the local citizen of his own destiny, while the increasing importance of state and Federal intervention to constrain local choices is apparent. The nonlocal center where resources for planning and service are abundant has become the chief locus for social innovation. Yet fiscal partnership between the locality and these larger units of government of necessity limits the autonomy of a local community.

The issue of centralized planning—an increasing reality in social work practice—will need to be squarely faced if we are to free ourselves from our ideological distortions of social reality. We have seen the growth of planning responsibilities in public health, public welfare, and urban renewal organizations. Much of this development to date has been located in executive departments, and our sense of community comprehensiveness has frequently been outraged because we have observed that the competition between public departments is frequently as sharp and severe as that which once characterized relationships between voluntary agencies.

This has necessarily raised the question of whether there is any provision in our political framework for coping with this type of competition—a mechanism comparable to the voluntary welfare council in its dealing with voluntary agency competitiveness. It can be suggested that a mechanism does exist in our political envi-

[16] Daniel Bell, *The End of Ideology* (New York: Collier Books, 1961), p. 402.

ronment, namely, the central executive office of government found at all levels. In several municipalities the mayor's office has begun to assume the kind of integrative responsibility over executive departments which has traditionally been carried by voluntary welfare councils over voluntary agencies. In these communities the mayor has brought together his Commissioner of Welfare, Commissioner of Health, and Director of Housing or Urban Renewal and in his own cabinet sought to integrate their approaches to fundamental social problems in the municipality. This integration has been challenged as being essentially unstable or dictatorial. It is argued with equal vigor that the basis for our democratic process permits the total citizenry of every jurisdiction to exercise its wishes by frequent elections; the acts of the mayor or of the executive officer in pooling the efforts of his own executive department heads are therefore subject to the constant review of the electorate. It is possible that the conception of the voluntary welfare council, representative of the public interest, has sufficient vitality to be extended to government.

Similarly, there has been in recent years an attempt to use the governor's office to bring about an integration of executive departments at the state level. California has brought together for more effective planning the departments of public health, mental health, and public welfare. In Pennsylvania, there has recently been advanced a proposal for a council on human resources to encompass these interests in the executive branch. In some less populous states, departments of public welfare and health have already been merged into one executive branch. In certain very populous states, such as New York, the governor's office has established interdepartmental committees with strong staffing responsible directly to the governor.

At the Federal level, this development is not so clearly discernible, although the organization of the Department of Health, Education, and Welfare itself a few years ago was a major step in the attempt to bring together the executive interests in public health, mental health, welfare, and education in one manageable administrative unit. This trend may not continue, for there has been persistent talk of a separate cabinet post for health which would

suggest the strength of counterinfluences which derive from the special interests previously discussed.

It is also possible to envision a continuation of the present competitive situation between various centers for planning with each one focused on a special interest. Political scientists frequently seem to agree that the essence of democracy is the freest competition between special interests. In this view, special interests are neither evil nor undesirable but are the best assurance that the great variety of human needs will be ultimately served by the fullest expression of differences free to compete with each other. This theory has been advanced by authors as diverse as Sills, Banfield, Dahl, and Truman.[17]

The period in which we are living is obviously difficult and exciting. The outcome is uncertain, and there is ample room to argue for either of the preceding approaches. However, whichever we choose, one consequence for professional practice in community organization seems inevitable. Social work's concern with community planning needs to develop skills, not only in the traditional enabling processes, but equally in the political processes, in an understanding of conflict, and in negotiation, bargaining, and diverse strategies which can be utilized to reconcile differences.

Political knowledge and skill to achieve one's ends have often been considered by social workers to be unprofessional. We have somehow believed that strong advocacy of a particular point of view and the development of techniques to achieve those ends violate our professional commitment to the democratic process. We have generally ignored the fact that other professions, such as the law, have been built largely around the adversary principle, which assumes a conflict of interest. Professional expression is guided by ethical and legal limits in the promotion of client interests.

The question for us is whether our commitment to professional neutrality and noninvolvement is to continue to sustain our professional practice. If it is, it can be predicted that our contribution

[17] Banfield, *op. cit.;* Dahl, *op. cit.;* David Truman, *The Governmental Process* (New York: Alfred A. Knopf, 1951); and David M. Sills, *The Volunteers: Means and Ends in a Natural Organization* (Glencoe, Ill.: Free Press, 1957).

to modern life will lie largely in the coordinative realm—coordinative among organizations that share common interests. The requirements of the new community demand skill in advocating special points of view and in living with other professionals who advocate competing points of view. Thus social workers may be concerned with planning in health, youth development, or housing and each worker may be a respected member of the profession. Each may seek to engage the support, interest, or collaboration of the other. Each may succeed or fail in varying degrees and still be professionally reliable.

On the other hand, if we choose to seek a new level of reintegration so that we can recapture the over-all community view, we cannot avoid the development of political skills which are essential to bring together into agreement the competing interest groups which characterize the public scene. It is our view that this reintegration will probably take place at the public level in a form consistent with our heritage of political democracy. If this integration does take place at the governmental level, it will have certain similarities to the integration at the welfare council level in that consensus will have to be developed among a variety of interests, and this will then draw upon the community organization skills with which we have become so familiar. In one sense, we will be concerned with coordination and consensus simply on a wider field, and it could be argued that our practice will not differ much from that of the past.

However, this type of integration will differ substantially from the one we have known in one significant respect. The voluntary welfare councils have succeeded because they have concentrated on bringing together groups of leaders, trustees, and organizations with a largely common foundation of interest and association. The voluntary council has been able to screen out those likely to produce major conflict divisiveness, and to concentrate attention upon those who accept the standards and patterns expected by the voluntary council.[18] However, if we are to have community planning in the executive branch of government, the dynamism of our political

[18] See Martin Rein, "Organization for Social Innovation," National Conference on Social Welfare, 1963.

processes makes it impossible to be so self-limiting. Therefore, the new forms of planning will of necessity have to deal with potentially and actually conflicting areas of interest in each community. The challenge which will be placed upon community organizers then will be how to deal with openly conflicting interests and how to bring them together in a general community approach. This type of conflict handling will call upon the skills and knowledge of all the social sciences—sociology and psychology, with which we are familiar, political science and political economy, with which we are unfamiliar.

Identity Problems, Role, and Casework Treatment

by HELEN HARRIS PERLMAN

THERE IS AMONG US TODAY a common malaise, a sickness of spirit, a "dis-ease," that has been recognized and delineated both by psychoanalysts and by social scientists. It has been the theme of a rising tide of literary and pictorial artistic expression in the theater of the absurd, in the novel of the diffused personality, in paintings without form or structure. It has been called by many different names, but its characteristic syndrome is the loss of, or lack of, a sense of identity. When it is chronic, it is called "identity diffusion"; when it is acute, "identity crisis"; and when it becomes a concentrated pursuit, "the quest for identity."

Its symptoms are these: the person is permeated by a sense of inadequacy, of confusions and self-doubt, of worthlessness, of aimlessness, of having no place in his society, no direction in which to go, no goal. He is pervaded by a melancholy sense of futility, of inability to "take hold," or by a restless, directionless pursuit of questions for which he can find no certain answers: "Who am I? What am I? What am *I for?* Where am I going? Why? What is my place and purpose?"

The explanations and reasons for the prevalence and pervasiveness of this existential malaise have occupied the minds and energies of philosophers and behavioral scientists in increasing numbers over the past years. It might almost be said, if one were to be flippant, that these thinkers and investigators seem to have found their identities as unravelers of the mystery of why other people have not. At any rate, the causes that seem to be agreed upon are so complex, so involved with all the technological, automated,

sped-up changes in ordinary living within a destruction-threatened, outer-space-oriented world that they all but defy being caught, halted, reversed.

Social work stands among the several helping professions that stubbornly affirm the importance of the individual human being and of the importance of *inner* space—whether that inner space is within one person or within the family cluster or within a community. Social workers doggedly attend to the business of trying to free man's energies and spirit so that he can lead his life with some sense of worth and dignity and purpose. This is why we remain intent upon helping people whose life circumstances or whose troubled spirits corrode their being.

Those people have many problems, but they are also victims of the general malaise. They often suffer from acute identity crisis or chronic identity diffusion. They do not call their problems by these names. Indeed, they usually come to us with problems that are more tangible, more immediate—problems of interpersonal conflicts and disturbances or of unmet needs that are usually visible and verifiable. But what they say with their eyes as they anxiously scan our faces for signs of understanding, and what they say with their sighing or apathy, by their stiffened or wilting bodies is: "Help me to know what to be and how to be, and what to do and how to do, and where to go and how to go, better than I can alone. Help me to find myself and my powers in a situation in which I am lost and overpowered." Problems of identity accompany, or underlie, or are the products of, many of the other problems that beset the clients of caseworkers.

Caseworkers have been particularly aware of identity problems in adolescents. Their sensitivity to the problem in this age group derives from the fact that the literature on adolescence names it as a nuclear conflict in this life stage [1] and from the fact that adolescents themselves often express it freely and frequently. Some identity struggle is normal for this period when, in the words of a now old-fashioned poet, the young person stands "with reluctant feet where the brook and river meet." The struggle becomes a problem

[1] See particularly Erik Homburger Erikson, *Childhood and Society* (New York: W. W. Norton & Co., 1950).

when the questions as to who and what and why I am become so obsessive that they undermine the usual work and relationship tasks the adolescent is supposed to carry. When this happens the adolescent is often sent for casework or psychiatric help, though the problem is usually stated in terms of his symptoms—"he is delinquent"; "he is failing in school"; "he is 'acting out' in rebellious or self-destructive ways."

There are other groups of people, also typically the clients of caseworkers, in whom we have not so clearly recognized the problems of identity diffusion or identity crisis. Unmarried mothers on ADC comprise one of these groups. (To be sure, they are not often within the attention of the sophisticated caseworker. Perhaps they ought to be. By any criterion they ought to be the concern of social work.) Here is a woman, one of a mass of women, whose identity is ambiguous to the total community, then to the social worker, and basically to herself. Who and what is she? To the community she is a woman or girl who, out of lust or mishap, has violated the role of unmarried female. To the caseworker, who only rarely sees her, she is a relief client, who qualifies for her check as long as she harbors her child and has no other income. To her child, she is a good or bad mother who has no husband to be his father. To herself—? One wonders what her sense of herself is—how she sees herself—what she feels herself to be and to be becoming. Maybe she never had a sense of self, of identity. Maybe her sexual vulnerability is one symptom of her lack of self-worth; of never having felt the continuity of belonging, of being, of becoming; or of feeling her identity as a member of an outcast, socially denigrated group with nothing to gain and thus nothing to lose. No one really knows what her problem is, because thus far no one has really asked. But if professional social work will give its attention to this girl or woman and to her child, the problems of the sense of selfhood may be found to be of profound importance in what can be done to change her and her life mode.

There are in our big cities today growing numbers of unemployed or sporadically employed men, marginal workers whose jobs are vanishing into the maw of automation. They range from the adolescent who enters the job market as a dropout from school

up through the middle-aged. They are predominantly, though not exclusively, Negro. They are sucked into the labor force by capricious industrial or agricultural needs here and there, and cast off when a production glut or a machine makes them useless. They have no skill, no steady occupation, no vocation, no reliable employment for their time and energies; their days are spent "hanging around" in desultory, apathetic ways. They feel like nobodies, they are viewed by others as nobodies, and consequently they act like nobodies—anonymous, mask-faced men with no sense of identity as workers, as husbands, as fathers, as men with rights and responsibilities. In the mass they constitute a serious social problem, the "dynamite" in the city slums. Social caseworkers see individuals among them now and again—the alcoholic, the young delinquent, the putative father of the newborn illegitimate child. Scratch the surface of any one of them and the sense of anomie and of missing identity will be found.

But it is not only among the economically poor or the socially outcast that one finds adults with pervasive uncertainties about themselves or about their direction. Aged men and women of all classes have problems of housing and medical care and leisure-time occupation. Threading through all these problems, undermining the aged person's adaptability, is the persistent sense of identity loss or insufficiency. Even if he had fair security about himself earlier in his life, the aged person's loss of role and of usefulness rouses the insistent cry within him: "What am I? Who wants me? What am I *for?*" Family agencies and medical and psychiatric clinics are overfamiliar with persons who have become physically or psychologically isolated from their family groups or friends and who have no attachments to regular employment, whether such employment is in paid work or in an avocation. Such people are literally afloat as personalities. Their sense of who or what they are and what they want is vague. They know their identity only in their roles as patients, as clients, as "needers," chronic seekers of help through attachment to someone or something—a therapist, a clinic, an agency—that seems anchored.

Among all these varied kinds of persons are varied problems which to a greater or lesser degree are associated with the diffusion,

the rootlessness, and the aimlessness termed "identity problems." For all of them caseworkers are challenged to develop some ways by which to instil or enhance the person's sense of selfhood, of social value, of being someone, of belonging to others, and thence of having some goal. I do not mean to imply that caseworkers have the wisdom or the means to cope with the pervasive problems of who and whither and why that are endemic in our society. That would be obviously absurd. I mean only that for the people we undertake to help we need to explore and to find every means we can by which to enhance the sense of inner security and social adequacy.

Here I come to consideration of social role in relation to problems of identity. The causes of a person's identity problems lie in his life history. A person's life history is his experience of interaction with people and circumstances which, for the most part, nurtured and exercised his sense of adequacy and mastery or which starved or inhibited that sense. In other words, a person's life history consists of his role transactions from infancy onward—of what he got and what he gave, of his being rewarded or deprived, recognized or rejected, in his child-parent, sister-brother, pupil-teacher, playmate-friend, worker-employer relationships and tasks. Caught and scrutinized at any moment in his life, a person would be seen as the product of this life experience. But he can never be caught alive and static. He is never only a product. He is also *in process*. He is in process of "becoming," although he is the product of "having been." His "becoming" may entrench what he has been. Or it may be different. This is the belief on which casework as well as every other therapeutic effort is based.

At the moment in time when a person comes to a social agency, he has one problem. It is that in some current and vital life role he is experiencing breakdown, incapacity, conflict, or lack of gratification. This problem has many variations because at any one time a person's vital roles are several and varied, and because the personalities and partnerships involved in those roles are varied. But the basic problem presented to the social caseworker is that of some unmanageable or insufferable role difficulty.

I suggest that problems of identity, at the time they are seen by

the caseworker (usually at a point of crisis or of acute stress), are related to role problems. They are related not only as they are explained by the person's previous and current role experiences. They are also related as they may be ameliorated, if not resolved, through casework's treatment focus upon helping the person find, engage himself in, and derive rewards from some vital role. Through work with the person to help him derive satisfactions in some current life role, his "becoming" may be signally affected. This proposal of the diagnostic and treatment relationship between role and identity problems requires some examination.

The experience of any one of us shows that in carrying any vital life role a person makes a substantial investment of himself. We "put ourselves into" being wife, mother, worker, student, child; in the terminology of psychoanalysis, we are "libidinally invested" in such roles. These so-called "social" roles are, for the human being who carries them, charged with emotion and feeling. The greater the deposit of such feeling in the role, the more wholly the personality is involved. The more wholly the person is involved, the more he as self and he as role carrier merge and become one.

Under satisfactory conditions, a person is nourished by the gratifications, the drive fulfillments, the social recognitions and rewards that his role responsibilities and behaviors yield. He comes to know himself securely; he presents himself to others with confidence in his being something and somebody, whether within his family group or outside. Some of us have single roles in which we make almost a total investment of self; others invest in several important life roles, and the self comes to have several dimensions. The essential point, however, is that the carrying of one or more vital roles at any stage of living is intimately related to our sense of self, to our sense of who and what we are. If this is true, it follows that one of the crucial ways by which caseworkers can help people to find themselves, to enhance their sense of identity, to increase their feelings of self-worth and purpose, is to help them to undertake and to carry some essential social role with adequacy and gratification.

Because one can never know in others what one has not experienced in one's self, I suggest this test of the relation of identity to

role: Look in the mirror, closely. Look deeper than that outer skin mask to which the Greeks gave the name "persona" and from which, interestingly, we drew the words "person" and "personality." Examine your identity. Who and what are you?

You will be able quickly to answer that you are of a given sex, age, nationality, ethnic, and religious group, the descendant of certain people of whom you are proud or tolerant, as the case may be, related by blood ties to a nuclear and more or less extended family group. Keep looking. You will say, "I am I, myself, me, with certain appearances and personal characteristics, and certain qualities of body, mind, and spirit." Have you placed yourself? Do you feel your identity whole, secure, complete?

Perhaps only a very few of us would; for only a very few of us carry that sense of internal confidence and security so certainly that we would be able to know and accept ourselves simply in our being. Most of us need to move one step further toward identifying ourselves through having some present viable connection with some other persons and/or some occupation. We seek to establish identity, not simply by being and belonging in certain social categories, but also by our being something and doing something in relation to other people. Most of us best recognize ourselves through what we do in our social interactions, in our relationships to people and to established life tasks. I am myself, yes. But most of us are pushed one step beyond—to define ourselves in social terms. What we say to ourselves and to others (in other words, of course) is: "I am a wife; I am a mother; I am a student. That is, I occupy a position and do something in one or more occupations." And our measure of ourselves, as well as our innermost feelings of confidence and selfhood, will be affected by the social recognition and the personal satisfactions or frustrations that these roles provide.

We know ourselves most surely through our daily occupations, whether they are avocational or vocational, and whether they link us mostly to other people or to activities that are socially valued. In short, we know our identities in large part through our social roles.

In some older societies, perhaps still in some parts of the world, a person may know his identity through his niche in a firm, stable, social structure. "I belong to this family," he may say, and he will

find echoing in the chambers of his personality the respectful acceptance he then sees in the eyes of others. But we and our clients live in a society that is "on the make," an action-oriented society. The most highly valued attribute of a person is not his ancestry, not his qualities of character, but rather the uses to which he puts himself, and his socially judged achievements. It is not by accident that the first question that rises in our minds when we meet a new person is, "What does he *do?*" or that the common greeting to be heard among us is, "How're you *doing?*"

One may deplore this. Indeed, Erich Fromm and others, ranging from existential philosophers to professional beatniks, have deplored the fact that man is becoming a functionary in our society, that he is losing his sense of individual being and humanness. This may be happening in many of the mechanized, lock-step roles we all carry to a greater or lesser extent. But the roles or patterns of interaction with which caseworkers are concerned are those that actually hold or potentially can be endowed with emotional nurture for the personality.

Obviously, the concepts of identity and role do not express the same things. The sense of identity is an accrual of largely unconscious feelings. It is felt as a sense of selfhood, of one's own powers, of the boundaries that separate the "I" from the "thou." The knowledge and acceptance of one's self, with faults and frailties as well as powers and strengths, with rights of one's own and concomitant responsibilities toward others, the sense of worth and of directedness—these grow out of continued experiences from babyhood onward of union, separation, and reunion with nurturing people, and of coping more rather than less successfully with the challenges and problems of living. These problems and these people that challenge us and sustain us are part and parcel of the roles we carry from our infancy. Our sense of identity is their product.

The roles that are vital to the development and qualities of personality (and identity) are obviously not trivial ones. They are not "acts" that we "put on." They are "real" and "earnest," our emotionally invested interactions. The concept of role, if it is to be of

use to a caseworker, must be viewed and understood always in its fourfold dimensions: [2]

1. To carry a role means to do something. So actions and behaviors are one aspect of role performance.

2. To carry a role means doing something with one or more others. So interactions, transactions, and reciprocations between and among several people are a second aspect.

3. Transactions between people are shaped and governed by their separate and joint ideas, expectations, and judgments of the attitudes and behaviors of self and others. So cognition, conscious ideas, will be a third aspect of role performance.

4. Ideas, expectations, and judgments of reciprocal transactions are charged with affect and shaped by drives and emotions. So these are a fourth aspect of role performance.

When role is viewed in these four dimensions, as a combination of doing, thinking, feeling, interacting, it is not hard to see how within a vital role a person's sense of selfhood and identity can be undermined or enhanced. When the requirements or the reciprocations of a given role are chiefly frustrating, the person feels undermined and under stress. When, on the other hand, a role brings satisfactions he feels rewarded and empowered. Because our clients come to us with difficulties in role functioning, because they bring the problems that they encounter in marriage, parenthood, employment, and so on, caseworkers are rather more perceptive of role stresses than of the potential and actual rewards to be found in adequate role performance. Thus we have not sufficiently explored the ego-enhancing, strength- and growth-promoting potentials inherent in commonplace, everyday roles.

The roles we carry may reward us and build into our sense of selfhood in a number of ways. Here, briefly, I can mention only a few. A socially recognized role defines a position, suggests a niche that a person occupies in relation to other persons. It is a kind of anchorage. Moreover, it connects a person to at least one other, offering a sense of belonging. A role expresses some function. So

[2] For elaboration of these four points see Helen Harris Perlman, "The Role Concept and Social Casework: Some Explorations; I: The 'Social' in Social Casework," *Social Service Review*, XXXV (1961), 370–81.

the role carrier's sense of being-to-a-purpose is underpinned. Roles that are relationship-oriented promise—and yield—social recognition and support. Certain roles provide purchase power; that is, they earn or buy desired conditions or things. And roles provide certain regularities of behavior which, then, free the person's energies for new ventures. (It goes almost without saying that the person's experience of deficiencies, distortions, or conflicts in his roles will undermine or rock his emotional well-being. There are times, too, when the carrying of a role may be at too great a cost to the personality, and a person may need help to find acceptable release from excess responsibility or from his social striving at the price of psychic stress. But this is another subject.)

An exploration of the kinds of rewards with which homely, everyday roles may be invested may offer the caseworker new sources of ego nourishment for his clients. We have tended to believe that if personality changes can occur the person will function more effectively in his various roles. What I suggest here is some turnabout in our perspectives, some consideration of the possibility that modifications or changes in personality may result from the exercise of ego functions that are inevitably involved in coping with role problems, and from the feelings of gratification which may ensue.

If a client can be helped to experience some valued role more satisfyingly, if he can be freed from the undue conflicts and stresses with which he (and/or his role partner) invests it, if he can get even the minimal reward of recognition for trying to handle himself better in his interactions with others, there will result for him some heightened sense of self as having both power and purpose. Obviously, such change will not occur simply because a caseworker urges or encourages a client to "be a better mother" or to "try to behave in school." To help a person shoulder and carry a familiar role in new and more satisfying ways or take on an unfamiliar role requires every therapeutic skill that casework offers. These skills cannot be detailed here. It can only be said that they consist of the releasing and supportive sharing of the client's feeling; of the projection and correction of his perceptions; of the consideration of connections between his today and his yesterdays, his today and his

tomorrow, between him (the client) and you, him and others, between what he feels and what he does, what he does and how it affects others, what he feels and does and what he thinks about it, whether he can see it and feel it differently, and what all this has to do with what he wants for himself. This repeated exercise of the client's ego functions, supported and infused by relationship, is the essence of the casework process.

The content, is the person(s) in some problematic role. The person feeling, thinking about, acting, and interacting in that role, the other persons or circumstances with which he is involved, the reality requirements and potential rewards in that role—all these are the content for caseworker-client considerations.

The following case example illustrates a severe identity problem and the possible treatment usefulness of a focus on role.

Wade X. is a seventeen-year-old Negro boy, brought by his mother to a family agency with the agreement of his probation officer. Wade has been involved in a number of delinquencies. He was with a gang when the police raided the house of a girl who claimed gang rape; he has stolen a car for a joy ride; he has smoked "reefers"; recently, after mounting defiance in school which culminated in his striking a teacher, he was expelled. But there is a margin for hope. Wade's mother is a responsible woman, worried about her son. Wade seems to have good intelligence. Moreover, he has registered in night school classes in art and psychology because he wants "to show" his teachers; in fact, he thinks he wants to *be* a teacher.

In regard to the problem of identity, a seventeen-year-old Negro boy has two strikes against him to begin with. As an adolescent he is likely to be involved in all the common, but nevertheless personally poignant, problems of "What am I, who am I, why, and where am I to go?" As a Negro he is likely to feel some alienation from the dominant groups in the community, some sense of being "different," of being undervalued socially.[3] But this particular boy, Wade, has troubles on top of all that.

[3] The title of a recent book by one of the Negro's most articulate interpreters, James Baldwin, states this problem: *Nobody Knows My Name* (New York: Dial Press, 1961).

In his first interview with the family caseworker, Wade was glib and blame-projecting. But he was also puzzled about himself. He said he sometimes wondered if he was crazy. He takes long walks but he finds himself going nowhere; sometimes he finds he is talking to himself. And his mother has told him that he does not have the right feelings about things. He wonders.

Fragments of past history began to reveal the reasons for this boy's particular diffusion of identity. Wade's father deserted when Wade was three and his older brother was five. His mother placed each child with different relatives in different cities. Wade lived with his cousins, an elderly, childless couple, and although they did not adopt him, he was called by their surname, Wade X. His mother visited occasionally, but Wade does not recall these visits, until one day, about four years ago, when she told him that she had remarried and that he could live with her if he chose. Not long afterward, Wade walked out of his foster parents' home "as if I was going to school" and came to live with his mother, his stepfather, and his recently arrived brother.

Now at home are his stepfather and his mother, Mr. and Mrs. Y.; his brother, who carries his own father's name, Charles Z.; and our boy, Wade X. Mrs. Y., his mother, speaks of her uncertainty about her current roles. She has continued to work because it did not seem right to ask her new husband to support her children. Should she quit so as to watch over her boys? She finds herself suddenly a mother, but of sons who are virtually men. Her husband accepts them, passively, and one of Wade's complaints is that his stepfather does not "come right out" and tell him what to do.

What one sees, as this tale unfolds, is not only a childhood in which this boy experienced severe discontinuities and disconnectedness, but also a present in which there is no firming-up of whom he belongs to or what he is. Added to the usual inner questionings in the adolescent about identity and goal, added to the usual identity struggle of the child of a minority group, is a particular life experience, past and present, that can only contribute to this boy's sense of vagueness, rootlessness, anomie.

Having come just this far in one interview with Wade and one with his mother, the caseworker himself is beset by problems. If

he is diagnostically astute, he sees many trouble spots. "Character disorder" is spelled out in the duration and pervasiveness of the boy's problems, in his bland affect, and in his disarming projections. There is the suggestion of a schizoid underlay coupled with some neurotic threads of conflict and anxiety about himself. What does one do about personality problems that have run so long and are so pervasive? Or about the galaxy of social problems that this boy presents?

Whatever the nature of this boy's pathology—and its nature and severity will be revealed as casework efforts bring out his responsive behavior—he has little sense of what he is, why he is here, what he is heading for. His restless, impulsive, mindless behavior is completely out of line with his good intelligence, certainly with his conscious goals. Neither his past nor his present anchors him. The caseworker's first goal, it seems to me, is to anchor him to his reality and then within that reality to begin to build supports for his sense of present being and direction. The caseworker has two major ways in which to do this. One way is through the therapeutic relationship; the other is through helping the client to focus upon some current role that concerns him, helping him to connect with it in some potentially gratifying manner.

The meaning of the words we use when we describe the casework relationship—acceptance, warmth, empathy, receptivity—is essentially this: "I look at you as a human being. But more than that, I see and hear you, I take you in, as a particular human being: *you*. You are worth my attentiveness, my interest, my lending myself to your need." By these demonstrated attitudes, the caseworker first affirms the applicant's unique identity.

Relationship deepens as the threads of emotional involvement in his problems are drawn from client to caseworker. The caseworker's responsive comments, his attentive receptivity, his guidance of the talking together, say, in effect: "I accept you, and I can feel with you. You are worth my help, not only because you need it, but also because you have within you the potential for coping with what hurts or frustrates you. That 'wanting' or drive in you, combined with the help I can offer you, is what makes our being together have a purpose." By these spoken or implicit affirmations

the caseworker injects into the relationship, not only support, but also stimulation; not only acceptance, but also expectation. "I take you as you are, in your *being*. But our business together is your *becoming*." This is what the relationship conveys.

As the client begins to feel himself "received," accepted in his own being, he comes to feel a sense of union, of at-one-ness with his caseworker. In part by conscious incorporation, in part unconsciously, he takes his caseworker's view of him into himself. The danger now is that some loss of self may occur, some blurring of the reality sense of his separate identity that we know as one aspect of "transference." The caseworker's clarity about the purpose and the focus of their work together—to help the client engage himself more effectively in some present life role—is one brake upon neurotic transference.

The client's role problem may actually be the symptom of basic personality problems, as Wade's problems are symptoms of his pervasive identity diffusion. But, while they may be seen and diagnosed whole, personality problems cannot be dealt with whole. They can best be identified, taken hold of, observed, and worked over as they show themselves in some partial and tangible aspect of today's life experience. To explore the etiology and course of Wade's many emotional and social problems would be to draw him into an endless labyrinth. Instead, I submit, the effort should be to relate to this boy as warmly and directly as he will allow and to help him tackle some part of his current life activity. Which part? The part, the role, that is most troubling to *him*.

For Wade the most troubling, most tangible, most consciously desired, and most readily achieved role is that of student. In this role he sees and feels his trouble plainly; in this role he knows his actions count; for other people will decide his future unless he undertakes some part in that decision. His success or failure in that role matters to his family, to his community, but even more to this boy's whole unfolding image of himself. Expelled from school, without occupation, without direction, he is a nothing going nowhere and talking to himself. If, on the other hand, he wants again to undertake being a regular student, with the caseworker's help, he may be restored to some sense of doing something, going some-

where, being somebody. This sense will grow not just because he resumes this role, but when, as a result of the continuing work with the caseworker, he and the other persons involved in his studentship begin to modify their feelings and interactions with one another.

When there is identity diffusion or when the multiplicity of problems feeds into the client's internal confusion the caseworker's focus upon some current role has particular usefulness. One value is that such a focus makes sense to the client. Usually, this is how he has defined his problem—as trouble between himself and another and/or between himself and a set of circumstances. He can talk about these troubles because they are out in the open, or so it seems to him, in the field of interaction *between* him and his opposite. Later he may be led by the caseworker to look at what is *within* him that affects the between-him-and-other, but at the start he is likely to be focused upon himself in an interactional situation.

Thus Wade, so far as he consciously knows, wants to resume being a student. It is where he is. Moreover, it relates to his ideas of becoming and to his wish for anchorage.

The caseworker who understands what a meaningful role involves will know that feelings, actions, reciprocal expectations, and interactions must become the subject matter of the work with Wade. Moreover, the concept of focus includes, not only the idea of partializing, but also that of viewing in depth. Thus, were caseworker and Wade to focus upon his problematic role of student it would involve talking over and delving into it in depth and detail. What brought about the breakdown in this role? How does Wade see it, and feel it, and think about it? What does he want us to help him do about it? What is he willing and able to put into the effort? To be a student he must act in certain ways. How does he feel about this? Can he, with the caseworker's help, begin to see himself as actor as well as acted upon? as affector as well as affected? Can he, supported in the relationship, get into the shoes of another—his teacher—and see his position? What difference does his being in or out of school make to his mother? Does he care? And so on.

All this repeated expression and examination of self as actor and

interactor, of self as affecting as well as affected, of actions as driven by emotions, of emotions and ideas as subjects for understanding and consideration—all this would be the content of interviews between Wade and his caseworker. Such interviews would have boundary and depth and vital reality for Wade because they would be about what he is and does and feels, now, in a clearly delineated interaction experience. Because one or more others are always involved in any role interaction, they, at different times and for different purposes, would have to be seen by the caseworker, too—probably one or more of Wade's teachers, surely his mother, possibly his stepfather.

The permeation effect of improvement and gratification in one role upon other parts of a person's life is not hard to imagine. If Wade found some security in being reinstated into the position of student; if his (probably awkward and tentative) efforts to control his impulses met with some recognition by his teachers, his mother, his caseworker, perhaps even by some of his peers; if he could see the steps by which he could achieve what he wanted for the future instead of blindly banking on "breaks"; if his mastery of school subjects gave him some pleasure—if these small changes could be made to happen, they would combine to bulwark Wade's general sense of himself. One could expect a rising feeling of self-respect, a growing self-awareness, some greater sense of direction and purpose, and, supporting all this, the feeling of being worth the attention of other people. His motivation to work on his problem will be sustained when the task seems encompassable to him, if he can see and feel some small achievement. Work on a tangible role promises such boundaries and rewards.

It may happen in Wade's case, as it may with any client, that for all that he wants to handle himself and his difficulty differently, he cannot. Try as he might, responsive within the casework interview as he may be, he repeatedly finds himself unable to carry through his perceptions and conscious intentions. When this occurs we know that there are imperious, unconscious forces at work. It signals the need for diagnostic, treatment, and goal reconsiderations, perhaps for psychiatric referral, certainly for such consultation.

A number of possible values in casework's use of role have been touched on here. Particular attention has been given to an idea that one way of solidifying a person's sense of his identity is to help him to shoulder a task and gain some sense of mastery in a vital life role. I have suggested that in carrying a socially valued role a person does something and therefore is something. The conscious sense of being something is most real when a person uses himself—his energies, his emotions, his skills—in carrying some work or tasks that he and others feel are important. His sense of self expands when, as in the casework interview, he is accepted and affirmed, and then supported as he learns to perceive and modify his feelings and actions. His sense of worth is bulwarked as the caseworker, a person he has become attached to, a representative of society, supports the importance and value of the role he works on, and his efforts. His sense of aim and of future is sustained as the caseworker keeps before him his realistic goals. His rewards for trying to see himself more clearly, to share his feelings, to modify his behavior, lie in his sense of mastery when he succeeds, in the caseworker's unflagging encouragement when he fails, and in the responses and recognition he gets from other persons who are involved with him. This last is of great moment, for the testing ground for selfhood and self-worth is the reflection of self we see in the eyes of the people who are part of our everyday life. The eyes of the caseworker are important mirrors; even more important are the eyes of the people with whom we live, from whom we want love or recognition, who affirm both our person and our value.

Sometimes caseworkers feel sad that they cannot give "enough" to make up for all the deficiencies of social and psychological nurture from which many of their adult clients suffer. Even the most intensive therapies fail of this. But within the boundaries of our roles as social caseworkers and of our knowledge and skills we do have ways by which to set in motion a chain of changing attitudes and behaviors which may nourish selfhood. The sense of self, of identity, grows with the effective use of one's small powers in relation to other people and things. Our daily life roles offer us and our clients the most tangible, immediate, and accessible opportunities

for testing the use of ourselves, for knowing our powers, for finding our purpose.[4] When a caseworker helps his client to find himself and feel himself adequate in relation to love-and-work-tasks he builds and strengthens that person's sense of personal identity and social worth.

Discussion

by FRANCES L. BEATMAN

In her paper Mrs. Perlman is in pursuit of a casework method of helping the untold numbers of people whose identity problems are either directly responsible for, or contribute to, troublesome attitudes and behavior. There is little chance of professional escape from dealing with these problems, since we find the manifestations of their existence and expression in every age group, at every economic level, and in every so-called "social stratum." One can discourse indefinitely on whether these problems are primarily the result of intrafamilial, social, cultural, or biological influences and try to develop treatment methods which accommodate a theory of a unique causative factor. Or one can recognize that the universality of the problem defies a charge to a single causative factor and that any effort at a theory of treatment will need to evaluate the contributions of as many disciplines as devote themselves to the study of people's psychic development and their relations to the outer world.

[4] Erikson has said these same things in these words: "Man, to take his place in society, must acquire a 'conflict free' habitual use of a dominant faculty, to be elaborated in an occupation; [and] . . . a feedback, as it were, from the immediate exercise of this occupation, from the companionship it provides . . ." ("The Problem of Ego Identity," *Psychological Issues*, I [1959], 110); and, earlier, "The sense of ego identity, then, is the accrued confidence that one's ability to maintain inner sameness and continuity . . . is matched by the sameness and continuity of one's meaning for others" ("Growth and Crises of the 'Healthy Personality,'" in Clyde Kluckhohn and Henry A. Murray, eds., *Personality in Nature, Society, and Culture* [2d ed., rev.; New York: Alfred A. Knopf, 1954], p. 216).

Identity—the affirmative sense of self—is on one level a highly personal, intrapsychic phenomenon. Mrs. Perlman's real contribution is that she properly broadens its definition to a psychosocial one. That is, personal identity is weakened and diffused or reinforced and delineated, not only by inner psychic processes, but also by social experience. In fact, Mrs. Perlman suggests that in many instances probably the only or the most effective approach to the identity problem of an individual is through his social experience.

Social roles are a way of conceptualizing and analyzing social experience. They atomize and partialize the totality of the individual's social relations. Thus the family member may perform well in the marital, less well in the parental role; well as a student, poorly as a friend. Roles, moreover, can be conceptualized as more or less specific. Thus, within the larger marital role, the individual may perform better in the more specific role of emotional support, less well in the sexual role, and so on.

The social roles in an individual's experience form a highly intricate, interlacing pattern and are in some respects mutually influencing. The subjective feeling of competence in role performance is bound up with personal identity. A person's feeling of self is inevitably bound up with the gratification and satisfaction he experiences in his role performance, or in a considerable part of his role performance. It is in this sense that Mrs. Perlman premises that an approach to the client's loss or lack of identity can be made via selective strengthening of role performance.

Mrs. Perlman's rationale is: If the individual in his cumulative life experience has not been able to evolve enough sense of his own identity to have some comfort in his capacity to carry his significant life roles, would it not follow that a positive adaptation to an important current life role, plus the integration of the social and emotional benefits of this adaptation, could begin to reverse the psychological process? Or, at least, would it not establish some new values about the self in relation to one important role and would not the competence and success gained in the carriage of this role make the individual less liable to further deterioration and self-damaging behavior? This thesis is based upon the observation that the identity problem, plus the lack of competence in an important

role, can combine to lock the individual into an aimless or self-destructive mode of living. This is a very appealing hypothesis. And it has direct bearing on our work with many clients, provided we are diagnostically accurate about the client and the selection of a role which is within his emotional, psychological, and social competence. It is imperative that we recognize that we must evaluate and establish the capacity of the client to integrate the greater social competence. For example, a borderline schizophrenic may not be profitably approached in this way without some prior therapeutic process having taken place in which a higher level of emotional integration is achieved. The diagnosis and evaluation need to establish the possibility of the feedback from improved social role performance to personal identity.

Thus, the selection of the role the client works on becomes very significant. Our own eagerness and ambitions for the client can serve to set up goals which are unrealistic in the light of the client's capacities, stability, emotional resources, and ability to integrate. So, for one person there may be the possibility of carrying the role of marital partner, but not the responsibilities of parenthood; for another, there may be the possibility of meeting the demands of a postal clerk position, but not those of an attorney—although his education may have equipped him for this profession; and for still another there may be the possibility of carrying on in the protected role of a nursery school aide, but not as a nursemaid who needs to make her own decisions.

It is obvious that there are many conditions which must be considered if we hope to help the client make some revision in his attitude toward himself and others through role competence. The mere acquisition of what can appear to be an adequate role performance does not necessarily affect the identity problem nor, indeed, give a measure of personal security. We have all seen too many cogs in the wheels of industry who are considered capable by their employers, yet who live with the constant self-created threat of dismissal; too many successful students who never knew why they passed an examination, and so on.

Our professional and personal experiences make us distrust any theory which would subscribe to the existence of a direct correla-

tion between the symbols of success in a role and the accumulation by the role carrier of appropriate feelings of competence and security about his capacity. We do know, though, that in adulthood —as in childhood—if there is help in integrating an experience and in extracting appropriate values and judgments from the experience, there can be an influence on the self, and the individual's capacity to differentiate what has been his contribution and what has been chance.

This task is a difficult one for client and therapist. For the client, it involves risk, great investment in the future, and some submission to an authority outside himself. For the caseworker, we have designed a role which undertakes to meet the client on a number of different levels. The caseworker is using the client's experience in attaining a specified goal to relate him to reality testing, to appropriate judgments about his behavior and his interpersonal relationships, at least as they are part of his chosen role. The client sees the caseworker as a representative of a social institution, one which represents acceptable social values, and through her support and psychological understanding he is attempting to identify himself with these values.

This is no simple assignment in which the manipulation of the environment automatically produces the desired results. For example, if the client has been convinced that his family's or society's expectation of him is that he run counter to acceptable behavior and standards, it would require a great deal of skill and conviction to capture his wish not to be scapegoated and victimized any longer. The worker in helping the client assume responsibility for some greater equipment in an area which is more distant from his more intimate, emotionally laden relationships—those with parents, siblings, and so forth—is nevertheless competing with the direct influence of these relationships. All these factors need to be considered despite the fact that we are talking of confining ourselves to a specific role accomplishment.

The possibility of positively influencing attitudes and behavior continues right through life. And while it is true that some changes in behavior attained later in life have neither the sureness nor the naturalness of that which one learns at the appropriate

time in the bosom of one's family, we have all seen changes effected in therapeutic experiences which produced a solid base for continued adaptability. We know too that for some, a lifetime of feeling emotionally deprived, uncertain about one's value and place, may mean that we can no longer count on that person's capacity to fit into the multifamily and many other roles which a full life demands. Narrowing the horizon, relieving the person of the pulls of many roles, and concentrating on one significant role may make the difference for a person between a continuous flight from self-responsibility and the capacity at least to support one relationship or activity, whether it be being a wife or a student or an employee.

On the more expansive or positive side, there is for some the possibility of enough gratification and security in at least one role to begin a feeding of self which can help to make up for the deficiency caused by the lack of feeding by others.

Woven into the experience of role adaptation and basic to its success is its signaling some communication between the client, the worker, and those involved in the developing role shift. Nothing that means real role competence takes place without some interpersonal activity and the development of some ability in this area. Just so, the development of competence in a role usually is dependent upon a growing capacity for relating to authority and self-discipline.

Mrs. Perlman has given us much to think about and to test in practice. This is not to say—and I do not think Mrs. Perlman meant to imply—that we have a new panacea for the no longer unique problem of our day—identity confusion. Rather, we must make an effort to take hold of the problem at some place and attempt some reversal of an insidious and corroding experience so that we can halt the deteriorating process by establishing with the client, at least in one area of living, some competence and therefore a beginning ability to look into the mirror and say, "This I know I can do and be."

The Community— New Psychiatric Treatment Center

by PHYLLIS POLAND

In the past two decades we have seen a tremendous development in community-based treatment of the mentally ill, and indications are that in the near future the community will more and more become the principal setting for psychiatric treatment. During these same years there has been a gradual shift of cases from the isolated, locked mental hospitals to the psychiatric divisions of general hospitals, and from there to "day" and to "night" hospitals.

This progress was made possible originally by the advent of effective treatment methods, such as electroconvulsive therapy, insulin, and psychotherapy. More recently, the discovery of the psychotropic drugs—the tranquilizers and antidepressants—has brought about revolutionary changes in the whole concept of treatment. These discoveries, interacting with positive changes in public opinion, have resulted in an immense expansion in the amount of psychiatric treatment provided for ambulant patients. We are finding that the majority can be treated in outpatient clinics and in doctors' offices, and now the home too is being used as a therapeutic setting.

At the same time, the partnership with the community has largely been a one-way process. In effect, we are saying to people, "Help us to treat and to rehabilitate our patients." We have made only a few tentative efforts to say, "Let us help you to *avoid* getting ill"; even less have we said, "Let us help you to become healthier." In other words, we are barely on the threshold of providing serv-

ices for the prevention of social and emotional disorders and for the active promotion of social and emotional well-being.

Developments at the Allan Memorial Institute, the psychiatric division of a general hospital and a McGill University teaching and research center, and at similar centers in Montreal, illustrate the growth of some of the social and community aspects of psychiatry. The Institute, which opened in 1943, was dedicated to a new approach in the treatment of mental illness. Both psychotic and neurotic patients could now be treated in a general hospital on the same basis as patients suffering from physical diseases, and the doors were open. It was set up to provide short-term—the average stay is from four to six weeks—intensive treatment with the aim of returning the patient to his social milieu as quickly as possible.

Another important advance in community aspects of psychiatry at the Allan was the innovation of the Day Hospital in 1946. The patient who attends the Day Hospital remains in direct contact with his family and his social setting throughout the whole course of his treatment and thus retains continuity with his place in society. At the same time, his relatives take part in the recovery from first to last; they take part in the full range of his gradual return to social functioning.

These factors were of great significance. The demonstration that the mentally ill could be treated in an open general hospital gave practical proof that mental illness is illness susceptible to treatment and recovery. This has helped enormously to change the public's attitudes. Perhaps just as important, these factors led to a change in thinking within the hospital itself. With the realization that the patient need spend only a short time in or at the hospital and can spend the rest of his life in the community, the hospital could be seen as a fragment of the community. This recognition made it essential to study the patient in relation to his social dimensions.

The implications for social work were important. Our training and experience had taught us a great deal about the family, the community, and the ways in which the community was organized.

The new setting provided plenty of opportunities to use our skills and to experiment.

It was evident from the beginning that family cooperation in admission, treatment, and rehabilitation is essential to the operation of a short-term, open-treatment center. The Day Hospital offers an even more dynamic situation. Since patients return home every evening, the relatives have daily opportunities to test their new insights and work through problems in interfamily and community relationships. It was logical to assume, therefore, that many of our patients and their families could best be served by the community social worker. The continuity of care thus provided benefits the family, the patient, the worker, and the hospital.

Close liaison with social agencies helped us to see more clearly the importance of keeping up the patient's social and cultural interests while he was in hospital. We recognized that, over and above the effects of the illness, if we take a person out of his social milieu, he is likely to deteriorate socially and to forget his social skills. The community's help was needed to insure that in so far as possible the patient did not lose continuity with his role in society. Accordingly, programs were devised to bring the Institute into closer contact with the community and to enlist the public's interest and participation in treatment and rehabilitation. Two of these programs, initiated several years ago, involve specialized community agencies and are related to employment and to public health.

Employment discussion group.—This group, formerly led by a staff social worker, was turned over to a government employment service officer, who also assists with individual job placement. This has been useful in many ways, but in particular it has helped to orient the patient at an early stage of his recovery to the idea of returning to work. The group discussions serve to remind him of the social skills that working requires beyond the actual skill needed in the job. In the individual interviews, much of the initial investigation and planning can be done at an earlier stage, thus making rehabilitation smoother.

Visiting nurses.—A second program, organized in 1956, has had

far-reaching effects, broadening the horizons of our thinking in relation to the community and introducing concepts of mental health into the work of an agency devoted to physical health. We were interested in public health theories and their introduction into the psychiatric field. It occurred to us that maintenance of health is a public health function; accordingly, we asked the Victorian Order of Nurses (visiting nurses) to help us maintain the health of patients on follow-up care. With their positive approach and family orientation, the visiting nurses proved so effective that their service was soon extended to potential patients who were awaiting admission to the Institute. Seminars and consultation provided by Institute staff aided these nurses to understand psychiatric patients and the emotional components of physical illness.

Two other programs started in 1957 involve individual citizens. The merit of these programs is that they put into practice the idea that healthy people should take responsibility for the sick members of society. It was recognized that healthy, well-functioning people can best preserve the patient's continuity of contact with society.

Companionship Program.—In this service, volunteers provide a sustained, friendly relationship with patients in activities aimed at increasing their abilities to communicate with others, reviving old interests, and introducing new ones. The social worker must carefully "match" patient and volunteer and endeavor to sustain the volunteer's interest and effectiveness.

Other centers in Montreal have broadened and expanded the use of volunteers. The Verdun Protestant Hospital, a large Provincial mental hospital and a McGill University teaching and research unit, has encouraged organizations and groups to perform a variety of service both within and outside the hospital. Of particular value is the work being done by high school and college students. These young people spend the summer months as temporary nursing assistants and in other positions. Impressed with the way in which the teen-agers met their experiences, the hospital organized tours for high school students in order to give them a better idea of mental illness. Students "adopt" individual patients, who benefit from contact with the open-minded and enthusiastic young people.

Lectures in Living.—This program at the Allan Memorial In-

stitute consists of a series of lectures given for patients, former patients, their relatives, and friends by well-known community leaders in business, professional, and public life, and in the arts and education. The sessions are designed to stimulate interest and provide practical information regarding courses, recreation, careers, and so on, which will encourage the patients to get back into the stream of everyday life. The lecturers have found this to be a new and enlightening experience. Both programs are, of course, an excellent means of public education.

These activities have also helped to demonstrate to hospital-oriented personnel that many things can be done to provide continuity of the patient's pattern of social living. The social worker's role—not always easy to define in a psychiatric setting—is to preserve and enhance the patient's contact with society, and to insure that he does not lose his social roles and skills.

Pre-admission home visits.—Clarification of these aims in treatment, together with some of the new theories concerning factors detrimental to health, led to the conclusion that social disorganization and disintegration of both family and patient have already begun by the time the patient is admitted to the hospital. To remedy this we set up a new service—pre-admission home visits.

Pre-admission home visits by the social workers are based on a number of theoretical and practical considerations. Studies have shown the disorganizing and disintegrating effects of enforced separation due to civil disaster, migration, and illness. The World Health Organization recommends that specific resources be made available so that people can get and give information in order to reorient themselves.

Information given prior to admission by family and patients helps them to orient themselves in relation to the illness and its effects on family functioning. The social worker tells them what to expect from hospitalization, explains procedures, and, most important, apprises the family that it will be required to take part in the whole course of treatment and rehabilitation. The attitudes of families thus prepared are strikingly different from those of families who were not visited before an admission.

Other concepts on which this service is based are those of Acker-

man [1] and Caplan,[2] who put forward the idea that when a person becomes mentally ill the family is in a state of crisis and temporarily forms a unit of ill-health. Caplan has shown that minimum therapeutic intervention at the point of crisis can be decisive in swinging the family's balance toward health.

Pre-admission home visits confirm the effectiveness of this therapeutic intervention. The family, often paralyzed by anxiety, can be helped to avoid hasty, ill-considered solutions detrimental to the future health of the family as a whole.

In arranging these visits, we ask that as many members of the family as possible be present and we encourage them to bring in anyone from their social milieu who is interested and may be helpful. We are finding that the inclusion of key people in their community at this time is of great benefit. At a point of crisis, people generally want to be helpful, and the visiting social worker can organize and channel these everyday community resources. This is sometimes not without its difficulties. At one home visit there were twenty-five people present, including neighbors, friends, relatives, employer, and priest. The small apartment was so crowded that the worker had difficulty getting near the patient and family. However, with the help of this group of key people there is little doubt that the family will be maintained during the course of treatment, that the patient will be kept in close contact with his social milieu, and that his social roles will be preserved.

Home Service.—The manifold advantages of the pre-admission home visits by social workers led to the development of the Home Service. Home visits by a psychiatrist, social worker, and public health nurse add new dimensions. Hospitalization may be avoided altogether in some cases, and treatment may be started at an earlier stage in others. Concrete help can be offered to family members who are suffering from the stresses of the situation. For example, a wife worn out by anxiety and sleeplessness will welcome both medication to help ease her anxiety and evidence of the team's concern for her difficulties.

[1] Nathan W. Ackerman, *The Psychodynamics of Family Life* (New York: Basic Books, Inc., 1958).

[2] Gerald Caplan, "Comprehensive Community Psychiatry," Institute on Community Mental Health, Honolulu, 1960.

This community-based team not only asks for help from a wide range of agencies and individuals, but also provides services to the community. In this two-way process, we ask the community to help us treat our patients and we also offer the community help in preventing breakdown. Through the Home Service, the public is offered consultation in the security of their own homes, thus encouraging earlier recognition of problems which, if untreated, could lead to illness.

Service for mentally retarded children.—Another community-based project with significant preventive aspects was organized by the psychiatric division of the Montreal Children's Hospital. The project came about because of the special problems of a mentally retarded patient from the near-by Indian reservation. The child was having serious difficulties at school, and it was decided that the social worker should talk with the principal. The school had no teaching facilities for retardates, and the principal was concerned because thirty children appeared to need special classes. As a result of this meeting, the school and the hospital cooperated in setting up a class. One of the teachers, who was interested but had no specialized training, was invited to spend time at the hospital's Special Learning Clinic. A hospital team tested the thirty children at the Reservation to select suitable pupils for the class. Half of the thirty youngsters were found to be eligible; the rest had normal or above-normal intelligence but were suffering from social and emotional disorders. They were referred to the appropriate agency or treatment center.

Later, a group representing the parents of the mentally retarded children approached the social worker for further help. She put them in touch with the local association for the mentally retarded and advised them how to ask the Government for assistance.

Marriage Counseling Center.—The Montreal Mental Hygiene Institute, whose major emphasis is on organizing projects for the prevention of illness and the promotion of mental health, has developed a number of interesting programs. Their Marriage Counseling center now does little marriage counseling as such; instead, it has a broad premarital counseling program consisting of individual and group counseling, general public education, and

special courses for ministers, lawyers, and others in key positions. It is considered that the counseling of an engaged couple offers one of the most favorable opportunities to prevent marital problems and to help lay the foundation for a good marriage. The Family Life Education Council provides other services for the promotion of family and mental health.

Well-Being Clinic.—The Well-Being Clinic, established in 1954, attempts to provide routine mental health checkups for community groups. Modeled on the established Well-Baby and Well-Woman clinics, its aim is to apply public health principles to the field of mental health. The clinic is under the Department of Psychiatry of McGill University and is staffed by members of the Allan's Social Service Department and by Counsellors Associated, a group of social workers in private practice. It is under the supervision of Dr. A. W. MacLeod, Assistant Director of the Mental Hygiene Institute.

In essence, the Well-Being Clinic gives the individual an opportunity to sit down for an hour's private conversation with an interested worker experienced in the mental health field. He is given the chance to hear himself as he outlines his daily activities. He is helped to assess realistically his ability to derive satisfaction and adequate financial return from his work, to handle his personal and emotional problems effectively, to achieve and maintain happiness in marriage and family life, and to play a constructive role in the community. He is asked to look at his goals in life and to discuss what he is doing to achieve them.

The purpose of the interview is that of appraisal. The objective is not to find out if problems exist—everybody has problems—but to see how problems are being handled. If, in the opinion of the counselor, the individual is grappling effectively with his personal ration of environmental difficulties and personal frustrations, and if his goals in life are realistic and he is working toward achieving them, his mental health is considered good, and he is told so.

Clinic services were originally offered to YWCA members enrolled in the "Health and Charm" course, and later to those attending a McGill University Extension course called "Understanding Ourselves." A section of the Protestant Teachers' As-

sociation applied en masse for interviews, and a large industry collaborated with us by setting up a model Well-Being Clinic attached to its own medical department.

At the university level, students in their final year at the School of Social Work are given "Well-Being" interviews as part of their course on psychiatric information. These interviews have the double purpose of providing a mental health service and of training the students to do similar interviewing. The students, in their turn, interview people in the community. The value of this service is perhaps best shown by the fact that the students themselves recommended to the School that "Well-Being" assessments be made available to first year students, with a follow-up interview in their second year.

A new development which began in 1963 is that of giving family "Well-Being" interviews in the home. This service was organized in cooperation with the Family Life Education Council. Our plan is to offer follow-up interviews to the same families once a year.

This work with healthy, functioning people provided firsthand knowledge of the social stresses in modern urban life and the threat they pose to health. This gave us valuable clues to the prevention of illness. For example, Bowlby,[3] Spitz,[4] and others have shown that social isolation is an etiological factor in mental ill-health. Many of the people seen in the Well-Being Clinic were socially isolated, and our evidence pointed to the possibility that many of them would have suffered in silence for a long time before their deteriorating mental health brought them to the notice of treatment services. Our experience further revealed that there is considerable unmet hunger for the type of constructive, self-revealing, face-to-face communication provided by clinic interviews. We have also reason to believe that such services can help to improve the health of the healthy.

Implicit in the development of the Well-Being Clinic is the conviction that mental health activities must be community-wide

[3] René A. Spitz, M.D., "Anaclitic Depression: an Inquiry into the Genesis of Psychiatric Conditions in Early Childhood," in *The Psychoanalytic Study of the Child* (New York: International Universities Press, 1946), II, 313–42.

[4] John Bowlby, M.D., *Maternal Care and Mental Health,* World Health Organization Monograph Series No. 2 (Geneva, Switzerland: 1952).

to be fully effective. They must be part of a network of well-organized services on all levels in the community. It is also clear that the small number of professional people available can by themselves never hope to provide such community-wide coverage. But we can and must impart the impetus, knowledge, and leadership to the "gatekeepers" and to other influential people who are aware of the need for and eager to provide such services.

Dr. Caplan, of the Harvard School of Public Health, is making a significant contribution in this field through his mental health consultants program. The validity of his concepts and programs was confirmed by our "Well-Being" work in industry.

During several months' work we were able to see only a small proportion of the people employed in the industry which set up its own Well-Being Clinic. We were able, however, to interest the nurses in its medical department in our ideas and methods. In their routine, yearly health talks, which formerly dealt only with physical health, these industrial nurses now include discussions with the employees on their family and social life, their attitudes toward jobs, supervisor, and fellow employees. The next step is, of course, to help departmental supervisors to spot early signs of stress among their staff and to help them either to deal with these problems themselves or to refer the employee to the company's medical department.

Similar procedures have been carried out in Montreal and elsewhere in the schools. This basic, grass-roots setting is one of the most productive areas both for prevention and for promotion of health. The schoolteacher can learn to recognize children's difficulties long before they become problems. These difficulties can frequently be corrected simply by bringing them to the attention of the parents; in other cases, by alerting the school's mental health consultant.

The conception of sharing responsibility for mental health with the community's "gatekeepers"—the teachers in schools, the supervisors in industry, and so on—leads logically to the conclusion that the ultimate responsibility for prevention of illness and promotion of mental health rests with families themselves. This principle of public health, which has proved so effective in the area of physical

disease and health, must now be more widely introduced into the mental health field. To do so, the professionals must ask themselves some basic questions.

First of all, are families willing to take on this responsibility? From experience, there is reason to believe that the answer is "yes." When professional workers have offered services to families in the community at large, and have not confined their services to the ill and the maladjusted, the response has been almost overwhelmingly enthusiastic. For example, the Montreal Marriage Counseling Center has a long waiting list for its discussion groups for engaged couples, and the number of groups led by the Family Life Education Council grew from twenty-nine in 1960 to over two hundred in 1962 due to public demand.

Another question that professionals must ask themselves is: How can we help families to help themselves? First, we must make available to them the knowledge, however limited, that we now possess. Next, we must continue and extend research into the positive factors that will enhance the health of the healthy, as has been done so successfully in nutrition.

Dr. John Bowlby has stated his belief that families have a basic urge to solve their problems and to achieve health in the fullest sense. Let us do all we can to help them to achieve their desires.

Schizophrenia and Family Therapy

by VIRGINIA M. SATIR

FAMILY THERAPY IS A NEW APPROACH to problems familiar to all who work in the field of mental health. I define it as a method by which all persons currently in a family, in which there is an identified patient with a symptom, are asked to come together at the same time and in the same place.

The theory that the patient should be seen in the context of his total family is based upon the premise that the patient's symptom is as much a manifestation of his interpretation of the action, interaction, and reaction of his parents as it is a manifestation of him. When I use the word "parents" I am always thinking of three simultaneous relationships: male and female; husband and wife; and mother and father. Seeing the family together makes it possible to understand the network of actions and reactions of everyone in the family, and the symptom is seen as one form of action and reaction.

The "schizophrenic family," that is, a family in which there is an individual clinically labeled as a "schizophrenic," can be described in a general way as one in which the parents of the schizophrenic child (who may, of course, be over twenty-one) behave as though they are strictly bound by rules which do not permit them openly and directly to criticize each other, or to disagree with each other about each other; thus they create the impression that they are duplicates. Their differentness cannot be acknowledged, and their unspoken criticisms and disagreements are reflected in a caricatured and thinly disguised way in their child's behavior. No two people are exactly the same, and if the husband and wife keep up the illusion, with each other, with their child, and with the

outside world, that they do not have disagreements, that they are not different from each other, and that they do not have critical feelings toward each other, their "delusion" will be reflected in the child's behavior. The parent's picture of supposed perfection, implying exact similarity, says to the child, "Be like me. Be without anger; do not disagree." To attempt to do this is incompatible with reality, growth, the development of individuality and sexuality. The patient then has to develop a pattern of behavior which can accommodate: "I am growing, I am not growing. It is real, it is not real. I am an individual, I am not an individual."

In the context of family therapy, schizophrenia is considered one of several symptoms which indicate family dysfunctioning. Like other symptoms, it is a comment on the person, a sign that his growth has been distorted, while at the same time it is an SOS, giving clues to the presence of pain or trouble in those persons who have survival significance for the child, such as parents. If we consider schizophrenia a symptom, then "schizophrenia" also becomes a descriptive term which labels an individual's behavior as strange to those who observe him and interact with him. Other symptoms in other contexts carry the messages that a person's behavior is sick (psychosomatic illness), stupid (mentally retarded, underachieving), or bad (delinquent, criminal, alcoholic, narcotic). Family interaction will be different as symptoms differ.

Concepts of individual psychotherapy usually point to an etiology of symptomatology within the individual who has the symptom. In contrast, as a practitioner of family therapy I see a symptom as an outcome of a family learning system which involves parents and their children, for whom they are survival figures. The parents will be the models from which the developing infant learns his blueprint. The blueprint evolves from concepts that the child forms about labeling (what he calls things, people, and ideas), and from the meaning he attaches to those labels, a process I call "coding." He learns to label and code both himself and others, both in his private world and in the outside world.

Each individual is unique, even though some people try to deny it, so inevitably each parent looks different, sounds different, and has different ideas, all of which the child must integrate in his

blueprint. The ease with which he is able to do this will depend upon the techniques his parents have worked out for recognizing their differentnesses, for explicitly labeling them, and for integrating them in order to achieve jointly desired outcomes. I should add, parenthetically, that all families have to deal with a paradox of learning. The child does not know that the parents do not know that he sees and interprets them, and the parents do not know that the child does not understand why they do what they do. The child acts as though the parents see and know him as he knows and sees himself. The parents act as though the child knows them and sees them as they see themselves. These illusions are not discovered until either the child or a parent behaves in some unexpected way. Yet this surprising behavior occurs because the child acts consistently with his level of growth, and the parent acts consistently with the fact that adults have many habitual automatic responses which the child has not learned to understand. This dilemma of "not knowing" can become another positive means of learning by which the child develops his blueprint, but only if parent and child are able to be explicit with each other.

A child develops his blueprint by what he hears his parents say, separately and together or to others in his presence; by what they tell him directly, separately and together in his presence; and by what they permit him to do, separately and together in his presence. The child will seek to unify his experiences in these situations, and so far in our studies with families we have outlined five general ways in which he does this.

A child may reject his mother's way and accept his father's way; conversely, he may reject the father's way and accept the mother's way. A third possibility is that he will reject both mother and father and will choose as a model a grandmother, an older sister or brother, or some person outside the family, such as a teacher or a probation officer. In functioning families the child takes what fits him from both his mother and father. The schizophrenic solution is to choose neither mother nor father, and to behave as if they are both the same, thus trying to fit the illusion of sameness presented by the parents to the child as reality. This idea of reality, reflected by the child, is delusional.

Whether parents are able to be explicit about their differentnesses will become an important factor in determining whether these differences will result in functional or dysfunctional behavior by their child. A schizophrenic family behaves as if there were no differentnesses. Clinically, their interaction appears to operate by means of prohibition and inhibition. Dysfunctioning families typically are those in which the parents lack self-esteem, but in a schizophrenic family the low self-esteem prohibits disagreement, since to disagree is coded as, "You are no good." In such a family the semblance of agreement protects each person from feeling inadequate, and sameness fosters the needed illusion of goodness and wholeness.

I am sure that many families operate in this way without anyone developing schizophrenic symptoms, but I expect this would only be possible were there no outside stresses. I define "stress" as any required change which is difficult to integrate, and all families know that even a happy event—a new baby, for instance—brings about necessary but temporarily stressful changes. Nevertheless, the feeling about the change is tempered by the pleasure in the event. In schizophrenic families, however, any new demand is interpreted as a loss. If the demand is caused by an unhappy event —a catastrophe, a death in the family, a move downward in the social scale, a financial setback—the sense of being unable to cope with the disaster is overwhelming. If a family with a schizophrenic tendency has the luck not to experience a cluster of stresses, however, it is possible that no one will develop untoward symptoms.

All dysfunctioning families have difficulty in handling disagreements, in receiving and giving criticism, and in manifesting individuality, with the result that they will have trouble in expressing themselves as males and females, in handling dependence and independence, and in dealing with authority. The schizophrenic patient reflects the presence of all these confusions. He acts as though he were both little and big, weak and strong, male and female.

Every person in a family, and outside it, has a communication system, a premise system, a coding system, and an expectation of outcomes. "Communication" is the process by which two people

give and receive meaning, and check out that meaning in relation to each other, while "coding" is the meaning a person ascribes to that which he labels. The "premise system" represents the conclusions a person makes about his image of others and the image that he believes others have of him. The system works like a series of mirrors, with the person posing complicated questions: "How do I see me?" "How do I see you?" "How do I see you seeing me?" "How do I see you seeing me seeing you?"

It is impossible for husband and wife to have identical premise systems, and they must learn to discover and make room for each other's systems, as well as learn how to handle their differentnesses, so that they will be able to achieve jointly desired outcomes. Explicitness with each other about differentnesses will create an opportunity for the two people to grow and to become close to each other. If they cannot accept their differentnesses and cannot be explicit, their unexplored conflicts and confusions will result in a distortion of growth for them and their children. Accepting each other's differences also implies that these two people will make choices on the basis of what is fitting rather than on who is right. If two people react to differentnesses by blaming each other, their conflict will make each one feel isolated, devalued, and incapable.

Perfect communication is obviously impossible. If a person's words and expression are disparate, if he says one thing but seems to mean another by his voice or his gestures, he is presenting what I call an "incongruent manifestation," and the person to whom he is talking receives a double-level message. The whole unsatisfactory interaction is a "discrepancy," which can be easily solved if people are able to be explicit. "Did you really mean that?" or, "What did you really mean?" or, "You don't look as if you really mean that" are common statements about discrepancies. Usually, the person asked the question is able to be explicit, and the double-level message is clarified.

In a dysfunctioning family, however, the discrepancies are not explicated. The parents manifest themselves incongruently, and their children receive double-level messages. One such manifestation occurs when what is said with words does not fit the way one looks, or the way one sounds. If a woman hurts her child with an

unfriendly embrace while saying, "I love you," the child receives a double-level message. Communication analysis deals with this type of discrepancy.

A second type of incongruent manifestation occurs when one looks and sounds in a way that does not fit the situation. Suppose that a parent gives a child a swimming suit and says, "Don't go near the water." Here we have an example of this type of discrepancy, which is relevant to an individual's coding system. A swimming suit is to swim in, but one is told he cannot go to the water. In schizophrenia, the coding system has been badly distorted. If a mother gives her schizophrenic child a swimming suit, he may show this distortion by denying that there is any water in which to swim, or by sitting down on a picture of a lake.

Another incongruent manifestation occurs when how one looks and sounds, and what one does, do not fit with the label that one wears. I call this "role-function discrepancy," since the function and the label do not match. If a parent asks a three-year-old child to make a decision for the parent, the child has been asked to perform like an adult while he is labeled "child." This puts him in an impossible situation because his perception of what is expected of him gives him an unreal idea of who he is.

All of these discrepancies are present in schizophrenia. They will be found in other types of symptomatology, but in various forms and degrees. Whenever discrepancies exist for a child, he will be unable to grow in a way that will permit him to manifest his independence, his authority, his sexuality.

At the Mental Research Institute we are in the process of making minute analyses of these discrepancies, hoping in the future to be able to study symptomatology more exactly in this context.

Discrepancies do exist in all human transactions. What distinguishes the functional family from the dysfunctional is the way in which the discrepancies are commented upon. The functioning family is one in which decisions are made in terms of what fits rather than in terms of who is right. The techniques for handling differentnesses will be clearly communicated. Decisions will be made in terms of time and situation, and each person's view of reality. To illustrate with a trivial example, a child may declare

himself in favor of lamb chops for breakfast, but in such a family he will be able to accept the fact that everyone else prefers lamb chops for dinner. Perhaps one parent does not care particularly for lamb chops at any meal, but he or she will be willing at some point to eat them so that the child may enjoy his favorite delicacy. Each person in a functioning family will be able to make choices and decisions for himself in accordance with his age, in terms of his needs and wishes, assets, and liabilities, operating within the particular context in which he finds himself. He will be able to take responsibility for his choices and decisions as well as for the resulting outcomes. In other words, each person in a functioning family learns to take charge of himself.

Family therapy is one of the two forms of therapy involving interactional concepts which is in use today, the other one being known as "group therapy." Since both therapies are oriented around groups, the therapist is able to watch an interaction going on before him among his patients. Group therapy is characteristically made up of patients who are peers. In family therapy there is a group of individuals made up of both peers and nonpeers, the powerful and the powerless, the young and the old. By observing the interaction between the adults and children, and between children and adults, the therapist is able to see where each person is in terms of his present conclusions about himself, and he can also discover more easily the data on which these conclusions are based. Within the family therapy framework there is, additionally, an opportunity to analyze carefully the internal thoughts and feelings of the family members as they are revealed by questions about how each manifests incongruencies and, further, by analysis of the discrepancies. Treatment consists of the therapist making explicit the presence of a discrepancy, and in learning through explorative questions how each member interprets it and thinks that it came to be, both in other people and in himself.

When he works with an individual, the therapist is part of the interaction, since there are only two people. The therapist cannot easily focus on the interaction between the patient and himself. He hears the patient's report of his internal thoughts and feelings, and his interpretation of those processes, but he must also be able to

understand, or to try to understand, what reactions in the patient are a response to the therapist's behavior.

Since it is difficult for any person to make a reliable report on how he himself looks and sounds (simply because no one is able to look objectively at himself), one can only be an authoritative reporter on what he meant or what he felt. A simple illustration is the experience of hearing a tape recording made by oneself. One hears an unfamiliar voice, one's own voice, but others who listen to the tape can easily identify the voice.

The clinician working with one individual has experience in taking clues about how the patient is feeling and thinking from the way he looks and sounds, and in matching that with what the patient says. When the therapist recognizes a discrepancy, he understandably asks himself, "What does the patient really mean?"

The members of the patient's family are in a similar dilemma; that is, they are receiving double-level messages. The therapist's advantage is that he is not bound by the same rules regarding what he may report. He is able to be explicit about what he sees and hears, feels and thinks, and is able, because of this, to comment directly about discrepancies.

For example, a schizophrenic patient in a family therapy session might remark that he had only one eye. The therapist could interpret this statement as the patient's attempt to say that he was only partially understood, that one parent did not understand the other parent, so that they gave him only a partial picture, and that he was unacceptable to his parents because he was incomplete and helpless.

In all dysfunctional families it is as though there were rules against commenting, and/or commenting directly, and the therapist must try to discover the explicit meaning of a discrepancy; that is, to discover the relationship between what is meant and what is manifest; to discover also the relationship between what is manifest and what was expected, and how what was expected was related to what was happening among all the members of the family.

The clinician working with one patient can observe discrepancies, but he has more difficulty seeing them in himself. It is even possible that he may, without knowing it, manifest incongruently,

so that the patient receives double-level messages, thus putting him in the dilemma he faces within his own family. This suggests two advantages in the use of the group. The therapist, by dealing with more than one person at a time can get a clear picture of how the patient manifests incongruently and how he reacts to double-level messages. Secondly, if the therapist finds that he is vulnerable to the same kind of discrepancies, he will be able to check himself.

Any idea on the therapist's part that he may be God, mother, or judge makes him apt to send out double-level messages. If he acts as a judge, he will presume to know what is right. If he behaves like a mother, or parent, he will present himself as a nurturer and omnipotent. If he thinks he is God, he will send out messages that he is omniscient. Since no human being is omnipotent or omniscient, and since there is practically nothing about which there is a universal right or a universal wrong, any messages about being God, mother, or judge are double-level in and of themselves. The knotty question for every therapist is how to be an expert without being omnipotent, omniscient, or nurturing, and without recommending what is right or wrong. I think the therapist can avoid this best by using himself as a model for the processes of getting and receiving meaning, while adding his special knowledge about human growth and development, about interaction, and about communication.

One of the therapist's chief values is that he was never involved in the initial survival or with the initial blueprints of his patients and he cannot now be. He is a figure from the outside who must be reacted to, since one cannot *not* react to whomever is with him. Every individual has his own processes for integrating an outsider, and observing them helps the therapist to see where each person is in terms of his present level of growth in respect to autonomy, authority, and sexuality.

No doubt it is apparent by now that the techniques for family therapy with schizophrenia do not differ from the therapeutic techniques used for other forms of symptomatology. Of course, some symptoms require a greater emphasis on a particular aspect of family integration. In schizophrenia, for instance, the therapist must make a thorough exploration of the patient's premise system

so that the patient can be "unhooked" from his present conclusions about himself, which he gained from his respective models who denied their differentnesses and who presented a picture of perfection and a negation of individuality. More digging is necessary with such a family before they are able to acknowledge the presence of differentnesses and make them explicit. One of the chief problems in handling schizophrenia, or any symptom of character disorder, is that the symptom has often been reinforced for years by institutionalization.

We are now beginning to take a new look at the diagnosis and treatment of psychological problems, a new look at what we have been doing and how we have been doing it. The implications of the family therapeutic approach for mental health in our society are relevant to prevention, clinical practice, organization of mental health services, the training of clinicians, the understanding of human behavior, and, consequently, to symptomatology.

These mental health services are psychiatry, psychology, social work, the counseling services—in short, all the services which employ the people who wear the sign, "I help." Were the family therapeutic approach to be more widely employed, one of the obvious changes would be to arrange the mental health services in a way which would not segment the family. If our agencies could be combined into generic centers for human problems, in which the total family unit could be treated, the various specialists could each provide special knowledge, in much the same way that they do in a general hospital. Unfortunately, our present organization of social services helps to create the very problems we would like to alleviate. It is not unusual for one child to be in an institution, another to be seen by a child guidance clinic, and the rest of the family to be on public welfare. In such a predicament there are, in effect, three separate situations, each of which has a homeostasis of its own, with the result that the family may be further segmented by the treatment. It is also not infrequent for several members of a family to see different therapists, which creates family therapy at the level of the therapists. They get very smart, but what about the patients?

Preventive therapy is of great importance, and the advantage of the family therapeutic approach is that it enables the therapist to

identify incipient symptoms in other members of the family. It is possible in the family therapeutic setting to deter the development of pathological processes in other family members.

Diagnostic and clinical treatment procedures could be made much more effective if all the family were seen from the beginning. Much time could be saved because there would be no separate, and perhaps conflicting diagnoses, and because duplication of efforts would be eliminated. Diffusion among agencies, as well as segmentation of families, makes it possible to perpetuate a family's dysfunctioning.

If clinicians were trained with the family therapeutic approach as one of their techniques, they would be taught, in addition to psychology, about group interaction, communication processes, and semantics.

The family therapeutic approach suggests that there will be new opportunities to learn about human behavior as it functions both in the internal manifestations of individuals and in their interactions with others. It is to be hoped that these opportunities will make it possible for us to understand more about the complex relationship between human behavior and the development of symptomatology.

The Group Method in Foster Home Studies

by RUTH LIGHT STANLEY

In the spring of 1962, the Child Welfare Unit of District 7 of the Florida State Department of Public Welfare and one of the consultants in the Child Welfare Division of the state office of the department agreed to experiment with a plan to study foster homes in that district by using three group meetings with prospective applicants and one private home interview rather than the traditional method of an office intake and subsequent home interviews. We wished to try the group meetings in which people would be expected to involve themselves in considering foster care and its implications for them. We believed that we would have an opportunity to know people better in this manner; we thought that they could be stimulated and could learn from each other and from our staff. We aimed for stronger foster homes. If the plan proved successful, the procedure would save hours of individual interviews and staff time, and also would cut down mileage payments. Part of our plan also included teaching this new method to other districts if it proved successful. The consultant carried training responsibilities in the districts, had had experience with groups, and would be the leader of the meetings. This, then, was a joint effort on the part of district and state staff personnel to experiment, evaluate, and possibly develop training material for other districts.

Letters of invitation to attend an evening meeting were mailed by the district office to people who had made inquiries regarding foster parenthood during the previous three months. This letter carried a note of expectation that both "fathers" and "mothers" would attend.

Roles were assigned to staff members. The foster home-finder and the supervisor for the foster care unit were to greet our guests and assist them to make name tags. This served the purpose of introducing two people immediately. One of them would be making the private home visit, and one would no doubt be in occasional contact with those who became foster parents. The District Child Welfare Supervisor would open the meeting, welcome the applicants, express appreciation for their interest in the children of the community, introduce the staff, and then turn the meeting over to the consultant. All general matters in the meeting would be handled by the consultant, while the home-finder would be responsible for clarifying any matters pertaining purely to local policies.

The first meeting set the pattern for the remainder. Forty-five people attended—twenty couples and five individuals. They came from the middle-class economic group, and ranged in age from twenty-six to fifty-five. None was college-trained, but one was a graduate pediatrics nurse. Occupations of the fathers included those in skilled and nonskilled categories. They were very tense, and unfortunately had to sit on uncomfortable old chairs. However, it was quite easy to relieve the tension momentarily with a ready reference to the need for a "first-inning stretch" because of the chairs. Lightness of tone was used to ease tension, to gauge their response, and to indicate that there would be less serious moments during the evening.

In order to secure participation with the leader in a nonthreatening area, but nevertheless on a personal basis, after a few remarks the group members were asked how long they had considered applying to be foster parents. This question was asked also to lay the foundation for the agency to "catch up" with their thinking so that they could become acquainted in a more knowledgeable way on some common ground. The group responded readily. We learned that some people had considered this step for as long as a year. They were given recognition for this. Recognition was also made of the fact that now they would need to help us "catch up" so that we could proceed together to become acquainted. The point was made that they did not know us, nor we them, and this was necessary for the benefit of the children in whom we were both

interested in order that together we could know if foster care would be right for all concerned. No great emphasis was placed on this matter then, but we were trying to lay the groundwork for some serious self-involvement.

We believe that applicants need to have the opportunity of verbalizing what they have been thinking and feeling in regard to foster care before they are ready or able to assimilate information. We wanted to know their fantasies about foster care. Therefore, we asked them to help us get acquainted by introducing themselves, telling a little of their experiences with children, and how it was that they came now to consider being applicants for foster parenthood. Everyone responded freely. Each contribution implied something positive to which the leader could respond in both serious and light tone. Again the light tone served further to relax the group and sometimes to emphasize a point. Questionable details and attitudes were related to whatever broad, positive value the leader could sense in the statement. For instance, one person placed great emphasis on rigidity in certain religious teachings; here, the leader mentioned that the agency felt that each child should be given the opportunity to develop some personal philosophy of life which might help him to live more comfortably with himself and others.

As people spoke, we noted voice tones, apparent feelings, expressions, and interaction between spouses as well as content. A few examples of their contributions follow:

A short, stocky man, modestly dressed, spoke first in a calm, half-serious, half-light manner, and described their large home with many empty "crooks and crannies" which should have children in them since their own six children had grown up and left. He said smilingly that children would make him and his wife feel "alive again" and keep them "young." He was a cab driver and spoke with sympathy of seeing children at the local receiving home. His wife, a cross-eyed woman neatly and simply dressed, emphasized quietly what her husband said, adding that she wanted a chance to help children. These people sat comfortably together.

A young man, short, pale, impeccably dressed, and reinforced with a three years' perfect Sunday School attendance pin in his lapel, was a contrast to his wife, obese, serious faced, without make-up. This man

explained that they had one child and had also had experiences with children in Sunday School. They could have more children, but he asked of no one in particular, "What could you offer children with the world the way it is?" They wanted more children and felt that this was the way to have them. His wife solemnly agreed.

Another, a young law-enforcement officer, said that he and his wife had been married three years, did not know why they had not had children, but thought foster care would be a way to get them. His wife, with a bored and somewhat sarcastic expression, spoke of her husband's shift work, the fact that she "just loved children," and that she became "bored when he's gone." The "he's gone" was emphasized with a sideward jerk of her head toward her husband.

A small, neat, and birdlike elderly widow wanted thirty-two two-year-old boys to rear and send through college because she had been reared in a home with twenty-three children of her own age.

These illustrations demonstrate that the group seemed to represent the variety of approaches which we regularly received.

After some general recognition of the remarks and a statement regarding the obviously varied reasons for being interested in foster parenthood, the leader moved further toward the necessity of learning about each other and attempted to develop some understanding of the reasons for this, while at the same time trying to develop some identifications with the practices of the agency. She asked if anyone there would be willing to let anyone else in the group have his child on the basis of his then-present knowledge of those in the room. This was definitely a leading question, and of course they responded as implied. Then they were asked what they would feel they would need to know about prospective foster parents. Their response was quick and ready. The leader related each response to the implied basis and extended the thinking a little further. For instance, "understanding" was underscored, but extended to "interest in trying to understand"; "whether he would fit," to the concept that not all children and all homes are compatible, and so on.

The importance of thinking, feeling, and talking about all the areas was emphasized. The home study, without that term being used, was described as a period during which there would be an opportunity for those who continued beyond the first meeting to look with the agency at what foster care really was and whether it

seemed right for their family and the agency. Mention was made of questions the group and the agency would wish to ask in order to accomplish this. As various people brought up different aspects of foster care, opportunities were given for the following items to be touched upon by participants and leader. Each concept was reinforced, extended, and left as a subject to be considered further in their discussions at home and in future meetings. Some of these concepts were:

Children react in some way to the experience of separation from their families.

Children grow to love foster parents differently from the way they love their own parents.

Foster parents do not become involved in natural parents' problems; foster parents care for the children for the agency.

The difference between children, natural parents, and foster parents is a matter of degree and ways of handling feelings.

If an applicant asks for a child, he also deals with the child's caseworker from the agency, and has contact with the child's natural parents.

If a child thinks that people feel there is no good in his parents, he will doubt his own goodness.

Foster parents are asked to grow to love children, to help them grow up a little, and then to let them go.

Each time a child leaves, both the good and bad parts of his foster parents go with him.

Relationships shift in a home when foster children enter.

The caseworker helps foster parents look at problem behavior and deal with it.

Foster children are not available for adoption by foster parents.

The agency has over-all responsibility in planning for children.

The home-finder was asked to explain briefly what financial responsibilities the agency met, and the necessity for a medical checkup and sanitarian report on homes. Foster parents' responsibilities for clinic attendance, interest in schools, and so forth, was explained. Here the home-finder came firmly into the team, and the group had further opportunity to become better acquainted with her.

The leader then announced that there would be two additional

group meetings at night and one private home interview with each couple who wished to participate in further exploration. The group decided on the most convenient week night. An invitation was extended for those who wished, to take application blanks. The return of these by a certain date would indicate their continuing interest. For those who might not wish to do this, recognition and respect were given. As "homework," those who planned to continue with the meetings were asked to think about the effects of separation on children.

In our evaluation of this meeting, we felt that the following had been accomplished:

The responsibility of the agency had been established.

A positive identification with the agency's goals and staff was begun.

An understanding of the importance of the foster parents' job with the agency was started.

A beginning movement toward seeing the needs of children above the immediate request for children was stimulated.

Some factual aspects of foster care had been made clear.

Some indirect teaching of how to be foster parents was accomplished.

The importance and expectation of foster father were stressed.

Expectations of self-involvement had been set up.

Some people would reject foster parenthood.

At the end of this meeting there were some who stood together, talking. A few questions were asked of staff members. The tone was exciting, friendly, and an air of anticipation pervaded.

Eighteen applications were received. Interestingly enough, those people whom we thought were really seeking adoption did not return their blanks. Five of the eighteen applications were rejected by us before the second group meeting. Several of these—from people who did not speak English and had brought interpreters to the first meeting—were referred to more appropriate agencies. All people who attended the first meeting but who either did not take applications or did not return them were thanked by letter for giving their time.

Twelve couples attended the second meeting. In this smaller

group, couples began to emerge quite forcibly as personalities. The same pattern of thinking together and extending ideas was used. Interaction between group members was manifested. It was quite evident, also, that family discussions had occurred in the interim.

There was an interesting reaction to the "homework." A dead silence was met when they were asked about their thoughts concerning children's possible feelings about separation. In trying to determine what was producing this block, the leader found that they could not really consider the topic until they had discussed together quite frankly their own possible feelings about separation from the children if they became foster parents. When this was accomplished, they could move on quite easily to the possible feelings of children. There was considerable give-and-take between leader and group members, and between the group members.

The group was asked to examine themselves regarding whether or not they felt they could take certain kinds of confidences, as, for example, sex experiences, without being utterly shocked and reinforcing the child's feelings of badness. One said that she would hate to take it but she would, "and would then try to guide them right." Another wryly commented that "nothing much shocks me these days; there is so much in the paper, and you know these things go on every day." She thought it would be better for the child to get the experiences out in the open. One of the men added that he felt it was important to listen without condemnation. Another man explained to him that condemnation only caused rebelliousness and guilt.

The discussion moved to children's seeking limits. They were asked to remember their own childhoods and think about how they tried to find the limits. Some direct teaching of the testing period was included here, in both light and serious tones.

The question of what children call foster parents was brought up by the group and discussed with obvious sensitivity.

When the group was asked what all this meant in terms of their applications to be foster parents, one said, "I don't know about the rest of you, but I have a question about whether I could be a good enough foster parent, after looking into my inner of inners." Her honesty was recognized. The comment was made that perhaps

others in the group had similar feelings, and that the agency frankly was not sure about people who felt they knew everything and could handle every situation perfectly, because we felt this was not realistic. The same applicant felt that "sincerity would be the quality that came through even if you made a mistake." One man thought that an adult should apologize to a child if he made a mistake, but another father assured him that then the child would have no respect for him.

In reality, this meeting provided opportunities to deepen the areas which had been touched upon in different ways in the first meeting. Repeatedly, the fact that "the agency and the foster parents work together in their areas for the benefit of the child" was emphasized. The leader also frequently asked: "In your inner of inners, how does this seem to you?" We felt it was important to underscore when it seemed appropriate that the agency was not seeking perfect homes, but people with whom we could responsibly place a child on the basis of knowledge and trust.

For the following week the group was asked to think about the parents of foster children. It was recognized that some might not wish to consider foster parenthood further, although we hoped they would. The group was friendly in a quiet way as the members left.

Everyone returned to the third meeting with the exception of one couple, mumps-ridden. The group was quite relaxed and friendly with each other and with the staff as they gathered. The leader started the meeting with a letter from a child who was leaving foster care. The letter, written in the manner of a sixth grader, touched upon many areas we had discussed in the meetings. Also, a short letter from a foster parent regarding his experiences was read. When the applicants were asked if anything sounded familiar to them, it was evident that they had caught the important points. Some smiled knowingly, others nodded their heads. These two letters set a quiet, reflective tone to the beginning of the meeting, and it was easy to move on to their "homework."

As we examined the importance of natural parents to children quite intensely, we learned of their discussions at home. One person explained: "We've been discussing nothing else at our home.

If I understand it right that the main object is to get parents and children back together if this is possible, then there must be some form of communication between them." We also discussed children's reactions to parental visiting or lack of it, and helping children to move out of care. All the discussion was free, easy, remarkably sensitive at spots, and indicated a tremendous degree of involvement. When it was concluded, each couple was asked to take the self-examination given below. They were quite serious as they talked together and marked the sheets. The instructions read: "Looking into your 'inner of inners,' please answer the following questions. If you would like to discuss any further at the time of your private home interview, place a star by those particular ones." Spaces for checking "Yes," "No," and "Maybe" were provided for each question. Question No. 20 produced the most conflict, with some "Nos" and "Maybes" checked.

1. Can our home take in another child or children without upsetting the apple cart?
2. Can our children share us with someone else?
3. Can we try to "take in" the child just as he is without trying to change him immediately?
4. Can we say that a child who is discussed with us will not fit into our home?
5. Can we be firm and kind?
6. Can we feel free to discipline the child of another person?
7. Can we work with the Agency on behalf of a child?
8. Can we observe the child and let the worker know how the child is reacting to change?
9. Can we feel free to talk over problems with the worker?
10. Can we make mistakes and learn from them?
11. Can we listen to bad experiences without condemning the child or parent who had them?
12. Can we respect the confidential information the worker gives us about the child?
13. Can we try to respect the child's good and bad feelings for his own family?
14. Can we love a child, grow him up a little, and let him go?
15. Can we try to help a child move on to whatever the Agency has planned for him?
16. Can we be courteous and friendly toward parents without getting involved in their problems?

17. Can we try to observe what the child does during the "testing out" period, and pass this along to the worker?
18. Can we try to understand problems which the child might have, with the help of the worker?
19. Can we try to handle satisfactorily any difficulties which might arise between a foster child and our own children?
20. Can we feel free in not loving foster children in the same way as we do our own children?
21. Can we laugh?
22. Do we have patience?
23. Can we talk *with* children?
24. Can we become angry with children and still not make them feel unwanted?
25. Can we try to understand what separation might mean to a child?
26. Can we share information with the worker?
27. Can we ask for help from the worker?
28. Can we enjoy the child of another person?
29. Can we feel proud to be foster parents?

Then the home-finder spoke of the anticipated visits with the couples, and the requests for the sanitarian's reports. There was some vying to be first and bantering among them about this. They were quite eager and arranged for hours when both parents would be home.

At the close of this meeting the District Child Welfare Supervisor had to announce that due to an unforeseen local situation, additional necessary monies for foster care might not be forthcoming for six months. This meant that no child could be placed until one left care. One applicant folded his arms and remarked he had read in the newspaper that "we might not have any money." At the same time, hands began to go up across the room and various people said, "We'll take them on credit!"

The spontaneous wave of friendliness which moved across the room at the end of the meeting was easily felt. Their informal talking with the local staff rather than with the leader was a good indication of their recognition of lines of responsibility, their identifications, and possible continuing contacts.

At the end of these meetings, we felt that the applicants had a real and positive identification with the agency's goals and with the

staff. They had lived up to agency expectations of attending and participating in the meetings; the importance of foster fathers had been emphasized and accepted; the foster parents' role seemed to be understood; the agency's general goal for children was clear; considerable information had been imparted, and we felt it was understood; anxiety had been reduced; some areas had been desensitized. There was no "pushing" for a child. They remained applicants. They understood the nature of their relations with children's workers and that teamwork was necessary. They also understood the importance for free, frank, and honest discussion. They appreciated the importance of the undertaking and the necessity for the private interview. There was eagerness for the interview to be conducted by someone they knew, and the groundwork for an interview in depth had been laid.

We had held conferences after each meeting and compared our observations and our notes. We felt very uncomfortable about two couples; mildly so, about another. Our discomfort was justified, it developed, when the private interviews were held. One of these couples withdrew, and we rejected one application. The man with the Sunday School pin and his wife did not follow through on the medical examination. (We learned that there was a problem of conception about which she and he did not communicate.) The mumps-ridden couple did not follow up their contact.

Of course, we were eager for the results of the interviews. We felt it important that they be held quickly. Each couple was relaxed and extremely involved in the whole procedure. They were honest, frank, and able to evaluate with the worker how their home could best be used. Personal information was freely given, and the applicants were able to evaluate its effect upon foster parenthood; their comments on the group meetings were positive. We discovered that some of the men had worked many hours overtime in order to attend without loss of pay and came without supper if necessary; one couple left ten people at a previously arranged barbecue; one father was, unlike his usual custom, the first to be ready to leave for the meetings!

We licensed eight homes, but the final test was to come: placement, care, and separation, then the foster parents' own evaluations

of the meetings. In February, 1963, we carefully reviewed the placements and the care that the children received in these homes. These foster parents have had children with all degrees of disturbances and physical difficulties, and dealt with some of the more difficult natural parents. They had had multiple workers. There has been one replacement of a child, and the agency must take the reponsibility for the original inappropriate placement. Without exception these parents have performed on a level which has been most unusual and most helpful to their foster children.

We met with them for help in evaluating the meetings, and told them why. We found them to be strongly identified with the agency and its goals; they were enthusiastic about their caseworkers. They honestly did not object to several workers, a necessary situation. They had strong convictions about their job, but they demonstrated in their discussion how far they had moved from "asking for a child" to using themselves to care for children. One commented, "We came to get, but we learned to give, and then we get." Another said, "We learned what social work was." Still another remarked: "I would like to tell you how much those meetings we had helped me. I don't know what I would have done without them. I called around many places and finally I called downstairs, and told them I had decided to take one of your children. She said, whoever it was, that they were going to have a meeting in three weeks and if I would give my name and address we could attend. Here we have had three of our own and we were going to have a meeting. Well, I decided I had to come but thought it ridiculous. I found out I did not know really as much as I thought I did. By the end of the second meeting I was really in doubt. Without those meetings I would have been sunk if they had brought the first little boy I had. He was emotionally disturbed. He could not have followed any closer the pattern you laid down . . ." In their discussion of all areas covered in the meetings, they were positive, enthusiastic, and expressed how the meetings had taught them to be foster parents. Each mentioned incidents with children which made a "bell ring."

The father who in the first meeting spoke of their large home with "crooks and crannies" and wanting children to keep young had this to say: "It is bigger than I thought it was. We figured we

had a large place. Actually, we did not think it would be as much fun, but I figure my attitude changed a little during the meetings. There was more to it than I realized, even though we had friends who were in it. It is a giving of ourselves, and we are getting a lot back. We have really enjoyed it. The meetings prepared us for a lot of things I never found in raising my own."

Another commented on the friendliness of the staff, saying: "I like the informality. I think I expected more of a lecture and everything was so informal and nice. You were so friendly, and yet there was an undertone that this was a serious business and in all of the meetings this was more or less stressed. If I had attended the first meeting and it was one of these holier-than-thou businesses, I would never have come back to the second one. If we had been serious all the time, we would not be fit to take care of children. I think with all our laughing and joking, there was an undercurrent that this is a serious business."

They strongly endorsed the fathers' participation, and they recommended that additional time be given to a discussion of natural parents. They thought more emphasis could have been placed on how much help they would receive from the children's caseworkers, because they were surprised at the degree of this. They also thought it would be helpful to prepare other applicants for the poor physical condition of the children.

In this meeting, they greeted each other and staff with ready enthusiasm. They talked together freely, compared notes, admired each other, and spoke truly lovingly of the children. In the private interviews, the particular use of the homes was discussed thoroughly, and this meeting demonstrated to each the full meaning of this.

One foster mother commented: "Something I am curious about. Does it help you to really get to know the people that come to apply, with the discussions and the way that *we* did it rather than the way *you* did it before, going to the homes? It seems you would get to know people better sitting together like we did." To us, the emphasized words are extremely important.

An additional element which we did not anticipate has resulted from these meetings. The foster care workers, who at this time are for the most part without formal training, have confidence in these

homes. With heavy administrative approval, they seem freer in their relationships. They are not suspicious of these foster parents, they do not have to act out any rivalries by proving the home-finder in error. They therefore relate to these foster parents more freely and use their energies more constructively and creatively. They do not expect the foster parents to carry the whole job because the foster parents spoke at length at their meeting about the degree of help they received from the workers.

In the use of this method, we feel there must be trust and respect among the staff. Each must fulfill his own role comfortably. The leader should be willing to find his way with a group. We do not feel that he or she must have group work experience, but he must have knowledge about foster care and conviction about people's ability to involve themselves in a discussion about it. We further feel that the applicants should enjoy the meetings. We have purposefully used the change-of-pace technique. We have used lightness, even to emphasize a serious point. We have especially used a light touch to desensitize a point. This lightness does not in any way reflect the main theme, which is quite serious, and which the applicants recognize fully. We have trained the Supervisor of the Foster Care Unit in this district to use this method. We have flown in a supervisor from another district to observe a series of meetings and plan to help her use the method in her district.

We believe that the quality of these homes surpasses the quality of other foster homes in this district. We have continued to use this method of study in this district exclusively, and our subsequent observations are similar. Five series of meetings have been held. However, we are certain we have lost some good applicants because they would not or could not come to the meetings. We may have lost them in any event. We will never know. We do know we have gained excellent homes. Whether these foster parents could perform their duties as well if we had used the more traditional method of study, we also will never know. We earnestly believe it is a method which could profitably be explored further, for we are of the opinion that some life energies have been freed. This energy is being expended creatively with the children. To us, this is the true test.

Approaches to the Treatment of the Socially Deprived and Culturally Different

by HAROLD M. VISOTSKY, M.D.

My experience with treating the socially deprived and culturally different has been primarily in clinical and community mental health settings in the Mental Health Division of the Chicago Board of Health. We have found that these patients present significant problems for the orientation of our approaches and treatment programs. It is not meaningful to use psychoanalytically oriented techniques in this group because of: (1) *our* mistaken models; (2) *their* transference difficulties; and (3) for *both of us,* problems in identification. This is further complicated by confusion around terms such as "motivation" and a rigid concept of what constitutes a family constellation. In reviewing our diagnostic evaluations, we found that middle-class patients were more prone to psychosomatic and psychoneurotic ailments, whereas the lower classes comprised the group with acting-out potential, personality and character disorders. Precipitating symptoms in the low socioeconomic group were equated with the middle-class request for help.

In correlating this with our own and with other studies, we found that the prognostic factors and acceptance for psychotherapy changed. Those patients who expressed a great desire for help, which involved more than just symptomatic relief, and who stimulated a positive reaction in the doctor, tended to be accepted for therapy more often than the others. These well-motivated patients were more likely to be diagnosed as having psychoneurotic reac-

tions, while the poorly motivated ones were more likely to have personality disorders. The well-motivated patients were apt to be considered good subjects for brief, nonintensive psychotherapy, and, in fact, a very high percentage of them were helped by such treatment. This created the danger that the poorly motivated patient would be avoided rather than being considered a challenge.

In dealing with groups of the socially deprived and culturally different, we found that at least four major problems presented themselves, both for the patient and for the therapist:

1. There was a severe difficulty in communication between the lower-class patient and the middle-class therapist or interviewer.

2. There were problems in assessing motivation. The therapist and the center team tended to use middle-class indicators of motivation, whereas the patients' symptoms were often indicators of motivation for help. This created difficulties in making valid assessments.

3. Many of these patients were poorly organized to cope with the everyday process of living. These individuals, poorly organized themselves, lived in confused, disorganized families and most often in disorganized, deteriorating communities. Such circumstances can only lead to viewing the outside world with hostility and suspicion.

4. The assessment of values which indicated health and maturity were significantly different for the therapist than for the patient. Frequently, patients who dropped from therapy indicated that it had already served to recompensate them toward a level and a function in living which were significant for them, whereas the Mental Health Center personnel often felt that they had dropped out because of poor motivation or disinterest in the therapeutic goals.

There were further problems in goal-setting. Goals for patients had to be consistent with reality—but whose reality? A comprehensive understanding of the patient's culture and his social setting was necessary in setting goals. There is a tendency to see all problems of low socioeconomic patients as universally the same. Furthermore, there is a limited range of services and techniques to deal with the multiple problems of adjustment and behavior neces-

sary if one is to live in a highly complex society. Moreover, the techniques follow the tenets of specific schools of thought.

Certain statistical features are characteristic of many of these groups, but particularly of ours. I think it is significant that 77 percent of the population of Illinois lives in urban areas. In only half of our families were both parents at home. Over 65 percent were on full public assistance, and 80 percent received some form of public assistance. Close to 92 percent received some care from public facilities. Our clinics were located in sections of high delinquency, particularly marked by illegitimate pregnancies and a high crime rate. There was considerable drinking, marital disorders, and other aspects of both social and psychiatric disturbance. The terminology employed to describe referrals to us frequently included such words as: "chronic"; "multiproblemed"; "disorganized"; "socially delinquent"; "nonmotivated"; "poorly motivated"; "hostile"; "apathetic"; "uncooperative." These conditions presented special difficulties in orienting our philosophy and techniques to this clientele.

As part of a city-wide public health resource, we considered ourselves a community mental health center rather than a psychiatric outpatient facility. In the differentiation between the two lay our philosophy; for while the outpatient clinic is mainly concerned with diagnosis and treatment, the community mental health center encompasses a wider scope of operation. In addition to diagnostic and treatment services, it is equally responsible for a program of preventive psychiatry within the community it serves. To be effective this must include active participation in, and the development of, other community resources as well as a carefully planned program in mental health education.

A community mental health center must be alert and sensitive to the needs and character of the community and able to assess its total strength in terms of the agencies and organizations which might participate in an all-out mental health program. It must also be prepared to offer direction and guidance in the coordination of these facilities.

Today the greatest challenge that faces the Mental Health Division is to discover ways of stretching to the utmost its limited

resources so as to meet the mental health needs of these areas. When it is a part of the local community, the Division can extend and strengthen its services by working with schools, churches, social agencies, juvenile officers, and other local Board of Health facilities in a productive two-way relationship.

On the one hand, these agencies can cooperate with the local center by providing additional services and support for individual patients so that treatment reaches beyond the center itself. On the other hand, the center staff can help community agencies develop a deeper understanding of mental health concepts. It can offer them consultation and guidance in the handling of problems presented by the adults and children they serve, and, by sensitizing them to danger signals, can increase the chances for early detection of psychological disturbances.

To further this sense of mutual responsibility, we have developed the concept of the implied contract. In essence, this means that when we accept a referral from another community agency, we expect that agency to cooperate with us in the treatment program. In one instance it may involve an earnest effort to keep a child in school even though he has been referred to the clinic because of disturbing classroom behavior. In another, it may mean assuming the responsibility of seeing that the patient does not fail his clinic appointments.

The theory of the implied contract was also applied to patients. We interpreted to them the services which we could explicitly provide. We also attempted to correct their implicit nonverbal fantasies of what we could do for them. Frequently, although their complaint was of a psychiatric nature, the tacit demand upon us was to solve a problem of economic want, or heal the pain of an abandonment, or eliminate the social injustices to which they were subjected.

We also explained how they were paying for their therapy, as, for example, by being on time. Appointments were made as they would be in private practice. Appointments that could not be kept were to be canceled by the patient. We showed them how they could further our services to them and to the community by cooperating in this fashion. This was a problem for most, since the

concept of time and responsibility was a confused one, but our staff worked hard with them, always commending their cooperation.

A frequently encountered problem was that of the poorly motivated client. Many of those who need and are eligible for our services are so burdened by the struggles and difficulties of everyday living that they have acquired a sense of hopelessness and defeat. They no longer have the energy to seek help; in fact, they are often suspicious when it is offered. Contrary to that of more orthodox psychiatric and social work techniques, our philosophy is that we must reach out to these people rather than wait for them to come to us. We used an approach of "benign aggression."

We encouraged all of our staff to seek out those patients and their families who, by our priorities, were in need of our services. We telephoned or wrote to those who did not keep their appointments, and usually we visited them at their homes. Those who explained absences on the grounds that they had no one with whom to leave their children were provided with baby-sitters (a volunteer program of our community churches and schools). Those who did not have money for transportation were given funds. We reminded apathetic and withdrawn patients of their appointments one or two days before the appointed time. This follow-up is not unusual for welfare services, but from the ivory towers of psychiatry we felt we were making gains. All this served to indicate to our clientele that, as experts on problems of behavior and living, we felt they had an emergent problem that needed, not only our immediate attention, but also their utmost cooperation and mobilization of effort. We validated for them that they were truly suffering from real problems. Our interest offered them some hope that most of these might possibly be alleviated.

We considered that the most effective use of treatment services in a preventive mental health program such as ours was a time-limited, goal-directed, crisis-oriented approach. We sought to concentrate our efforts on those cases that could be helped before a serious problem developed or before an acute problem became a chronic one. Many persons are at cross roads where skillful, short-term psychiatric assistance offered at a crucial time in their lives

can prevent further deterioration into emotional or social disorganization and, through helping them to cope with their situation, can direct them toward mental health. This crisis-oriented, therapeutic approach is based on the knowledge that treatment is most successful when it is offered as close as possible to the critical or crisis period.

In using this technique we hoped to set up a continuum of: early detection; treatment toward specific goals; interpretation of, and education in, the use of coping mechanisms in meeting crises; and a push toward mental health. In setting up such a program we needed a staff that had training or experience in truly eclectic schools of therapy. The task for the mental health movement, particularly in prevention, is to devise specific methods and techniques for preventing and treating particular disorders. What we call "illness" is often a result of maladaptation of the human individual to his environment. Modification of the dynamic equilibrium between the individual and his environment sets into motion a series of interrelated events whose final state we can predict only imperfectly. The goals of medicine are modest—a diminution of suffering from disease and the enhancement of the capacity to deal successfully with stress, but *not* the unattainable goal of elimination of disease and stress. Stress is necessary for growth and maturation. Therefore, goals must be specified in realistic and specific terms. The most effective use of limited resources also requires the fullest utilization of the psychiatric team and willingness to seek new approaches and explore modifications of standard techniques.

The answer, then, is not in the single-minded schools of thought, each spouting its own dogma, each posturing in a hierarchy of prestige. The one-to-one relationship, the concept of transference, recovery with insight, are all status symbols of the true approaches to treatment. Staffing of psychiatric facilities is often done in accordance with this system of values. By using these methods alone we have insulated ourselves from the sights, smells, and sounds of the social group that so desperately needs our intervention. This fact is pertinent, not only to psychiatric facilities, but also to social and welfare agencies, since so many of them use these same values, both in their practice and in their choice of consultants.

In seeking to become an integral part of the community we serve, we realized that we must keep open the pathways of communication. This depends upon our ability to learn as well as to teach and upon our willingness to listen as well as to speak. We also recognized that mutual respect and understanding, including provisions for adequate and appropriate feedback, among all the service agencies are essential if together we are to create the kind of climate in which the community's mental health needs can best be met.

Current studies indicate that the "psychiatric gap" will require many years to fill. It is therefore vital that available resources be used as efficiently as possible, and that those in allied professions be integrated with their particular skills into the psychiatric manpower resources. This can be achieved only through the development of a well-coordinated program between psychiatry and the community.

The problem of communication is a major one. Language is the most immediate and explicit link of communication between humans and the obvious medium through which the therapist can obtain information and bring about desired results. Nevertheless, verbalization, though fundamental in importance, is not the sole constituent of communication. Many of these individuals, adults and children, have been so profoundly deprived that conceptualization of their experience is at such a minimum that they are unable to translate a reality into comprehensible terms.

We found that to promote true communication the therapist must enter into the patient's experience to the fullest possible extent, seeing it as a reality rather than merely as a thought. We found that group therapy frequently allowed the nonverbal patient to communicate in a therapeutic relationship. In all groups the various levels of verbal capacity allowed one or more members to serve as spokesmen. They not only described their own problems and symptoms, but also prompted other members to participate. The session content cued hesitant patients into taking part, to a limited extent which gradually increased. We found that some patients frequently were able to respond to the verbal cues given by another patient, sometimes empathically derived, sometimes

intuitively derived, and frequently by free association. We enlarged the scope of the group process to cover intake and orientation groups.

Guided by the patients' range of experience, the therapist had to learn to read the past in regard to trauma and distortion, correlate his findings with their absorbed reactions, and verbalize for the patient the interaction. Their deprivations do not fall within circumscribed areas of experience; they are pervasive, confusing, disorganizing, and they constantly produce stress from without and within. Thus confused, overwhelmed by reality in themselves, it is not surprising that these isolated individuals are unable to communicate.

It is impossible for any one member of these large families to develop a strong and sharply defined personality. Unlike the planned large families of full-time and mature parents, these are overcrowded, with several generations living in the home. Their unrealistic kindness opens the door to any kinfolk, regardless of their own lack of space and inadequate facilities or furnishings. As Hertha Riese says:

> Acting without thought about their own children, guided by indiscriminate benevolence, these families pool their meager resources in the face of insuperable odds and of impending emergencies. Unable to anticipate the emotional, social, and economic consequences, they increase the baggage rather than the forces for combat within their inadequate environment.[1]

They are constantly on the move, they are resented by more affluent neighbors. The quality of their quarters is usually poor, they are undesirable tenants. The educational level is low. School changes are frequent because of the families' mobility, and the constant need to relate to new situations, without the ability to do so, overcomes both children and adults. The crowding creates an identification with the sum total of the families' indignities and is manifested either by depression or by aggressions.

Many of these people have been exposed in childhood and in young adulthood to terrifying experiences and distorting influences. When they find themselves in situations where they are out

[1] Hertha Riese, *Heal the Hurt Child* (Chicago: University of Chicago Press, 1962), p. 46.

of their class, they are overwhelmed by their inadequacy. Even when an opportunity is offered that might be beneficial and inspiring, it becomes repugnant and is often avoided or rejected. They constantly deny their own feelings or the ability to communicate freely—they cannot communicate to the therapist why they are not reacting positively to help and to good examples. The therapist who lacks understanding of this group becomes, in turn, annoyed and rejecting. Families are so chaotic and so confused in relationship that children literally have no concept, no self-concept, as to where they belong and where they are going.

The developmental task is an important one, and the search for identity is an important process in developing and maturing—search not merely for identity, but for an identity closely associated with self-esteem. Deeply ungratified children constantly search for a nameless gratification. Not knowing what they want, unable to recognize what could gratify them, they seek, they touch, they test everything and everyone; they resentfully destroy unrewarding objects. Their threshold for stimulation is low, their irritability is high; they are argumentative, aggressive, destructive, and unmanageable.

Many cities, large and small, face the problem of the newcomer, the hard-to-reach. These are people who possess little wage-earning ability, insufficient education, and few skills. Many have come to the city to find a better life. True, they may find some slight material gain, but this is offset by a society they do not understand; even more frightening, they are confronted by a society that does not seem to *want* to understand. The outcome is that the hard-to-reach person remains that way—confused, frustrated, and angry. In his simplicity he either stays away from his alien neighbors or expresses his resentment through acts and attitudes that create even more misunderstanding.

All of this does not indicate need so much for new techniques as for understanding. These people and their problems must be approached by staffs who understand them and who can communicate their understanding. The attitudes of the helping professions, then, become a significant factor in treating these groups.

There have been several useful studies:

1. Baldwin and Breese found that in parent-child relationships, accepting, democratic attitudes on the part of parents seemed to facilitate emotional and intellectual growth.[2] The children of such parents show accelerated intellectual development, emotional security, and control. Children of actively rejecting parents, on the other hand, make poor use of what abilities they do possess and display aggressivity, rebelliousness, and instability.

Our therapists were impressed with the fact that these studies could be related to other relationships than that of child and parent. The findings apply to the therapist-patient relationship even more significantly.

2. Whitehorn and Betz studied the degree of success achieved by young resident physicians in working with schizophrenic patients on a psychiatric ward.[3] They found that those who were successful developed a relationship in which the patient felt trust and confidence in the physician. They made less use of passive-permissive procedures and worked toward goals which were oriented to the personality of the patient rather than toward cure of the disease.

Here again, the conclusions also apply to other therapy relationships.

3. Heine [4]studied individuals who were treated in psychotherapy by psychoanalytic, client-centered, and Adlerian therapists. Regardless of the type of therapy they received, these clients reported similar changes in themselves. They agreed on the major elements that brought about the changes:

a) They trusted the therapist.

b) They felt that they were understood by the therapist.

c) They were conscious of a feeling of independence in making their choices and decisions.

d) The therapist clarified and *openly* stated feelings which the

[2] A. L. Baldwin, J. Kalhorn, and F. H. Breese, *Patterns of Parent Behavior,* Psychological Monographs, Vol. LVIII, No. 3 (No. 268), (Washington, D.C.: American Psychological Association, 1945).

[3] B. J. Betz and J. C. Whitehorn, *The Relationship of the Therapist to the Outcome of Therapy in Schizophrenia,* Psychiatric Research Reports, No. 5 (Washington, D.C.: American Psychiatric Association, 1956).

[4] R. W. Heine, "A Comparison of Patients' Reports on Psychotherapeutic Experience with Psychoanalytic, Nondirective and Adlerian Therapists," unpublished doctoral dissertation, University of Chicago, 1950.

client had approached in a less organized or hesitant fashion.

Attitudes of the therapist which were considered unhelpful were:

a) Lack of interest

b) Remoteness or distance of manner

c) Excessive sympathy

e) Emphasis on the patient's past history rather than on his present problems.

4. Fiedler [5] found that expert therapists of differing orientations formed similar relationships with their patients. The elements characterizing these relationships were:

a) Ability to understand the patients' meanings and feelings

b) Sensitivity to the patients' attitudes

c) Warm interest without emotional overinvolvement

5. Quinn found that the understanding of the patients' meanings is essentially an attitude of desiring to understand.[6]

It must be noted that it is the attitudes and feelings of the therapist rather than his theoretical orientation which are important, while his procedures and techniques are less important than his attitudes. Also, the way in which the therapist's attitudes and procedures are perceived makes a difference to the client, and this perception is crucial.

It must be realized that families who live in low-income areas cannot be considered as homogeneous groups to which uniform procedures can be applied. It is the fashion these days to talk rather glibly about the hard-to-reach segment of the population as though it were synonymous with the low-income population. If this attitude persists among people working in public health and other social welfare agencies, services developed for such groups are likely to end in failure. Multifaceted programs have to be developed that will appeal to the range of interest among these people, especially in urban communities.

Some of the alternative techniques which we have used in our centers have ranged from the directive-supportive to the educa-

[5] F. E. Fiedler, *Quantitative Studies on the Role of Therapists' Feelings toward Their Patients: Psychotherapy—Theory and Research* (New York: Ronald Press, 1953).

[6] R. D. Quinn, "Psychotherapeutists' Expressions as an Index to the Quality of Early Therapeutic Relationships," unpublished doctoral dissertation, University of Chicago, 1950.

tional and to the concept of the "circle of services." The circle of services uses a primary agency to organize and structure the services for a multiproblem family. Frequently, patients who come to psychiatric centers present major problems that require intervention by a series of agencies. For those patients whom we accepted for a psychiatric focus we felt it was our responsibility to provide the integrative and structuring factors in this circle of services.

In our educational approach we set up our crisis-oriented therapy, hoping to reach patients as close to the crisis as possible. In working through the crisis, in pointing out ways of coping with the stress, we hoped to educate these people as well as to treat them. We reviewed with them, following the relief from stress, the difficulties which led to the stress, the mechanisms by which it was lessened, and the behavior which could possibly prevent a recurrence of such a situation. It was our hope that this ability to interpolate from one crisis to another would be carried over. However, it was necessary to support other patients through periods of stress and then to terminate the intervention upon relief of the situation, inviting them to return when further help was needed.

In many of our operations it was far more important to orient our diagnostic inquiry from a frame of reference of health rather than illness. In trying to correlate the problems with the various social classes from a psychiatric aspect, we found that class four and class five have the higher incidence of hospitalization. The class four patient is far more accessible than one in class five. There is a great overlap in values and customs between the staff and patients. Therefore, in dealing with some patients we required changes in emphasis rather than innovations in technique alone: The delegation of a portion of care to other psychiatric professional personnel was impossible in some situations. Frequently, members of the patient's family had to be involved, and this was more effective than the classical concept of teamwork with patients. Although team approaches were frequently used in the diagnostic procedure, members of the family were most often included when therapy was concerned. Family members were frequently seen as co-therapists, but sessions with them were not considered so much therapeutic as consultative and supervisory. The role of the family

was valuable in reporting on what happened to the patient, supervising his medication, caring for him when the therapist could not; that is, a therapeutic role was delegated to a significant member of the family, while the therapist acted as a consultant to that member. Oftentimes, a patient's family made him sicker, and it was essential to discover which of the relationships with significant members of the family was at the core of the problem.

The reciprocity between the therapist and the family frequently meant doing things their way, finding out what was appropriate in dealing with the patient, observing their attitudes toward him, and listening carefully to their ideas.

Community agencies had to be drawn in—social welfare and homemaker services, medical and surgical. Coordination, which presented problems since each agency seemed to specialize in only one service, was handled when one agency was designated as the one primarily responsible. The work of any agency is impotent without clearly coordinated efforts of, and integrated relationships with, other helping organizations.

In dealing with the patient comprehensively, the roles of the significant members of the treatment team became blurred, and this blurring was necessary in the process of translating the conventional psychiatric roles into one of treatment. Frequently, the public health nurse saw the patient by appointment, the psychiatrist treated other members of the family and then consulted with the agencies, but it was often the social worker who actually treated the patient. Visits to the home were necessary, not only to see how the patient lived, but to allow him and his family more ease in relating to the therapist. This technique would change an entire relationship so that instead of the therapist being in control behind the desk, he became a visitor, and the patient and his family became the hosts. The patient gave the cues, and thus the whole setting was more comfortable and less anxiety-producing during particular periods of stress when a therapist made home visits.

In summary, group therapy techniques were particularly valuable with this group:

They allowed the relative levels of verbal performance in the group to aid communication of the relatively nonverbal clients.

They allowed us to see the group through the eyes of each member. Oftentimes the experiences related by one member stimulated other members to see their environment through the eyes of the group. Distortions were picked up. Individual hostilities and the background for these hostilities were more clearly defined when a single community was seen through the eyes of several inhabitants.

Use of the group allowed the therapist more comfort in dealing with his own anxieties and with his ignorance during the initial periods of learning about particular sectors in the low economic and socially deprived classes.

Family therapy provided organization in routes of communication between significant members of the family. It provided education in dealing with significant developmental and rearing practices. It provided motivations for the family (the more motivated members brought the less motivated ones to the sessions). It allowed the goals of a benign therapist to pervade the family and gave him an opportunity to set up models of behavior and for identification.

We used the value systems of some of these families in setting up demonstrations and projects which, although of a psychiatric nature, had other appealing and motivating stimuli. For example, in working with unwed pregnant adolescents, we felt that the families were distrustful and suspicious of public agencies. Most of these girls lived at home during their pregnancy, and the families were said to be "accepting of pregnancy in young girls; illegitimate pregnancy was their way of life." This we knew was not true. Many of these families had high hopes that education would solve children's problems, both economically and socially. We gave these girls, who had been previously excluded from school, an opportunity to continue their education. Special classes were organized, and the girls were accepted in a setting which was correlated with arrangements for prenatal care, with our social planning facilities, and with our psychiatric and psychological services. In addition, provision was made for all these girls to have their babies in a single hospital, which would allow us a long-term follow-up. We found that not only were the girls cooperative, but also that their families were cooperative in dealing with them. Moreover, they brought to us other problems relative to the family.

In working with the poverty-stricken the overwhelming need for services and the major undertaking of staffing such a program seemed to be herculean. However, I feel that this was a teleological response; that is, we were saying that we can do very little because the situation is overwhelming and we cannot get the manpower. But annoying questions kept running through our minds. This overwhelming problem—do we know what it is? Can we analyze and organize it? Can we set priorities that are coherent and integrated with a total concept of health and behavioral development? Can we apply the public health concepts of primary, secondary, and tertiary prevention?

I have found that we are uneconomical in the use of our services. Too often we take the time of three highly trained professionals, usually in a team approach, to make an assessment and diagnosis, only to reject a patient because he is too sick or, perhaps, not sick enough. Does this truly fit in with our concept of prevention and early treatment?

As professionals, can we not expend our therapeutic energies more generously in the public domain, in hospitals, schools, welfare agencies, health departments, on broad public issues related to all health, and particularly to mental health? We must support a higher level of professional work in these therapeutic centers, with critical evaluation of performance and imaginative efforts to devise new approaches.

As for staff, are they seeking insight in the patient, insight through depth therapy, when they must be trained in depth themselves? Are they trained in a variety of therapeutic techniques and approaches rather than only in the school of thought to which they belong? Are we truly eclectic in our therapeutic approaches? Do we understand the underlying principles of relationship which are part of the theories of procedures for treating patients?

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PAPERS PRESENTED AT THE 90TH ANNUAL FORUM MAY ALSO BE FOUND IN *The Social Welfare Forum, 1963* (PUBISHED BY COLUMBIA UNIVERSITY PRESS); and in *Guidelines to Social Action for Progress in Social Welfare: Report of the Post-Forum Workshop,* information concerning which may be obtained from the National Conference on Social Welfare.